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### Proving Deliberate Indifference: Next to Impossible for Mentally Ill Inmates

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## PROVING DELIBERATE INDIFFERENCE: NEXT TO IMPOSSIBLE FOR MENTALLY ILL INMATES

### I. INTRODUCTION

Mental illness is a debilitating condition that affects many people.<sup>1</sup> In prisons and other correctional facilities, the rate of people with mental illness is approximately three times higher than in the general population.<sup>2</sup> For an inmate with a serious mental illness, such as schizophrenia, mental torment may become exacerbated by the conditions he faces in prison confinement.<sup>3</sup> Instead of receiving needed treatment, the inmate may be left for days at a time in solitary confinement, left covered in feces in a hot, filthy cell with only water from a toilet to drink.<sup>4</sup> Instead of helping the inmate, prison guards may simply ignore his cries for help, or even worse, may taunt or abuse him.<sup>5</sup>

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<sup>1</sup> See Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (2003), available at <http://www.hrw.org/reports/2003/usa1003/index.htm>. "Mental illness" is described as "mental disorders" that include a wide range of "impairments of thought, mood, and behavior." *Id.* at 30. The level of such impairments can vary dramatically from person to person. *Id.* "Also, some individuals with mental illness have periods of relative stability during which symptoms are minimal, interspersed with incidents of psychiatric crisis. Other individuals are acutely ill and dramatically symptomatic for prolonged periods." *Id.* at 30-31. One court used the term "mental disorder" to characterize "organic functional psychoses, neuroses, personality disorders, alcoholism, drug dependence, behavior disorders, and mental retardation." *Ruiz v. Estelle*, 503 F. Supp. 1265, 1332 n.140 (S.D. Tex. 1980), *aff'd in part & rev'd in part*, 679 F.2d 1115 (5th Cir. 1982); *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525 (7th Cir. 2000). For a discussion of what mental conditions qualify as "serious mental illnesses," see *infra* text accompanying notes 131-32.

<sup>2</sup> Nat'l Alliance for the Mentally Ill, *Criminalization of the Mentally Ill* (2001), available at <http://www.nami.org/Content/ContentGroups/Policy/criminalization2001.pdf> (prepared for the 2001 Annual Convention); see also *infra* text accompanying notes 54-59.

<sup>3</sup> Human Rights Watch, *supra* note 1, at 58. This report describes how mentally ill inmates are vulnerable to assault, sexual abuse, exploitation, and extortion. *Id.* at 56. The report further explains that this vulnerability is heightened when a prison does not employ a sufficient number of trained correctional staff to monitor, supervise, and protect mentally ill prisoners. *Id.*

<sup>4</sup> See *id.* at 2; see also Dennis Cooley, *Prison Victimization and the Informal Rules of Social Control*, 4 FORUM ON CORR. RESEARCH 31 (1992).

<sup>5</sup> Human Rights Watch, *supra* note 1, at 82. An inmate's cries for help may take the form of bizarre or self-destructive behavior, such as cutting himself, masturbating publicly, or smearing feces on the wall. David Lovell & Lorna A. Rhodes, *Mobile Consultation: Crossing Correctional Boundaries to Cope with Disturbed Offenders*, 61 FED. PROBATION 40 (Sept. 1997).

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If the inmate attempts suicide to escape the mental torture, he may be stripped naked and thrown into an empty, cold observation cell.<sup>6</sup>

A disturbing example of correctional facility officers' treatment of a mentally ill inmate was reported in an Eleventh Circuit case from 1995.<sup>7</sup> In that case, Pamela D. Young, an eighteen-year-old woman, suffered from manic-depression.<sup>8</sup> She was sentenced to serve jail time at a city jail in Georgia.<sup>9</sup> Less than two months after entering the jail, Young complained to a jail guard that she was hearing voices.<sup>10</sup> The guard responded to Young's complaint by putting her in an isolation cell.<sup>11</sup> While in isolation, Young attempted to flood her cell with urine.<sup>12</sup> Because the urine dampened Young's clothing, jail guards stripped her naked and shackled her to a bed that had no mattress.<sup>13</sup> Young could not reach the toilet and, as a result, she was forced to urinate and defecate where she sat.<sup>14</sup> Young remained in isolation, mentally deteriorating until she became delusional.<sup>15</sup> In her delusional state, Young banged on the door repeatedly.<sup>16</sup> As a result, guards sprayed her with mace.<sup>17</sup>

<sup>6</sup> Human Rights Watch, *supra* note 1, at 3 (explaining that prison guards most often view prisoners with mental illnesses as disruptive and difficult and therefore place the inmate in solitary confinement cells).

<sup>7</sup> *Young v. City of Augusta*, 59 F.3d 1160 (11th Cir. 1995).

<sup>8</sup> *Id.* at 1163. "Manic-depression is an affective psychosis characterized by extreme and pathological elation alternating with severe dejection." *Id.* at 1163 n.2 (citing 8 MCGRAW-HILL ENCYCLOPEDIA OF SCIENCE & TECHNOLOGY 114 (5th ed. 1982)).

<sup>9</sup> *Id.* at 1164. The case originated when Young was arrested for stealing a pack of cigarettes from a grocery store. *Id.* at 1163. She was found guilty of misdemeanor theft and was sentenced to serve a ninety-day sentence or to pay a five-hundred-dollar fine. *Id.* Young was unable to pay, so she faced the jail sentence. *Id.* Before her transport to the jail, Young was placed in a holding cell. *Id.* While in the cell, she removed her shoes and underwear and set them on fire. *Id.* Setting the items on fire led to another charge for destruction of city property because the cell was damaged by the fire. *Id.* Young pleaded guilty to the destruction charge and was sentenced to another five-hundred-dollar fine or ninety days in jail. *Id.* Young's father had previously informed people associated with the judicial system in Augusta, Georgia, that Young was manic-depressive. *Id.* at 1163-64. He requested that his daughter be allowed to serve any jail time that she received at the Georgia Regional Hospital in Augusta. *Id.* at 1164. His request was ignored, and instead she was taken to the city jail. *Id.*

<sup>10</sup> *Id.* at 1164.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> *Id.* Young also reported that she was sprayed with mace by the jail guards as she was being escorted to and from the shower facilities. *Id.* at 1164 n.8.

Later, Young had a verbal argument with a female guard.<sup>18</sup> The guard hit Young in the eye with her fist while Young was still shackled to the bed.<sup>19</sup> The guard continued to beat Young until other guards intervened.<sup>20</sup> When Young brought a claim against the city in district court, the court granted the city's motion for summary judgment.<sup>21</sup> The failure to provide Young with adequate mental health care and the difficulties she faced in obtaining a remedy illustrate the problem addressed in this Note.

Part II.B of this Note explains that punishing inmates that exhibit symptoms of mental illness like Pamela Young, instead of providing needed treatment, is considered inhumane and contrary to the Eighth Amendment's protection of inmates from cruel and unusual punishment.<sup>22</sup> The Supreme Court has decided that prisons cannot deny inmates needed medical care.<sup>23</sup> Mental health care is included within the meaning of medical care.<sup>24</sup> Thus, denying mentally ill inmates needed mental health care violates their Constitutional rights.<sup>25</sup> Even so, Part III of this Note examines how mentally ill inmates face higher hurdles than

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<sup>18</sup> *Id.* at 1165.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* at 1163. Young filed a 42 U.S.C. § 1983 claim in the United States District Court for the Southern District of Georgia. *Id.* After the court granted the city's motion for summary judgment, Young appealed. *Id.* The First Circuit heard the appeal and concluded that genuine issues of material fact remained, and as a result, reversed and remanded the case for further proceedings. *Id.*

<sup>22</sup> The Eighth Amendment prohibits the use of cruel and unusual punishment against confined inmates. U.S. CONST. amend. VIII; *see also infra* Part II.B. The fact that a person is in prison does not deprive that person of certain constitutional rights. *See Turner v. Safley*, 482 U.S. 78, 84 (1987) ("Prison walls do not form a barrier separating prison inmates from the protections of the Constitution."). The Eighth Amendment is a protection for prison inmates, but jail inmates' protection is derived from the Fourteenth Amendment. Fred Cohen & Joel Dvoskin, *Inmates with Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 462 (1992).

<sup>23</sup> *Estelle v. Gamble*, 429 U.S. 97, 105 (1976). The Supreme Court held that this amendment provides the right to medical care because failure to provide adequate care constitutes cruel and unusual punishment. *Id.*; *see also infra* notes 95, 97-101 and accompanying text.

<sup>24</sup> Lower courts extended the right to medical care to include the right to mental health care. *See, e.g., Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996); *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991); *Seifullah v. Toombs*, 940 F.2d 662, 662 (6th Cir. 1991); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir. 1979); *Bowring v. Godwin*, 551 F.2d 44, 47-48 (4th Cir. 1977).

<sup>25</sup> *See infra* Part II.B.

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physically ill inmates when seeking to remedy an Eighth Amendment violation.<sup>26</sup>

As described in Part II.C, inmates may sue state actors for Constitutional violations under 42 U.S.C. § 1983 to obtain a remedy.<sup>27</sup> In 1976, the Supreme Court announced the first test for determining if the state has violated a prisoner's right to medical care: The inmate must prove the state's, or a state actor's, deliberate indifference to a serious medical need.<sup>28</sup> In 1994, the Court set forth a higher culpability standard in order to hold the state liable, requiring actual subjective knowledge by the prison official.<sup>29</sup> Lack of guidance by the Supreme Court has resulted in inconsistency among lower courts as to the meaning of "adequate medical care" and "deliberate indifference."<sup>30</sup> Given the complexities of mental illness and prison guards' general lack of awareness of mental health needs, the mentally ill face a tougher burden in proving actual knowledge than their physically ill counterparts.<sup>31</sup> For example, if untrained in mental health issues, a prison guard may not be aware of symptoms of a mental health crisis.<sup>32</sup> Liability is avoided because the guard simply did not have actual knowledge of a serious medical need.<sup>33</sup> This is not as likely with a physical condition, which is more easily recognized by a layman.<sup>34</sup>

This Note addresses the problem of the substantial barriers encountered by mentally ill inmates who attempt to remedy violations of

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<sup>26</sup> See *infra* Part III.

<sup>27</sup> See *infra* notes 113-21 and accompanying text. This applies to both government run and privately run prisons, just as municipalities can be considered state actors. See *infra* note 121.

<sup>28</sup> See *infra* note 98 and accompanying text.

<sup>29</sup> See *Farmer v. Brennan*, 511 U.S. 825, 837 (1994); see also *infra* notes 161, 170, 172 and accompanying text. Commentators have criticized the subjective intent requirement. See, e.g., Philip M. Genty, *Confusing Punishment with Custodial Care: The Troublesome Legacy of Estelle v. Gamble*, 21 VT. L. REV. 379, 390 (1996). One author identifies three problems with the Court's focus on the motivations of prison personnel in analyzing prison condition cases. *Id.* "[F]irst, the theoretical premise upon which the imposition of an intent requirement is based is wrong; second, an intent-based standard is unworkable in cases involving challenges to conditions of confinement; and, third, the use of an intent-based standard is inherently weighted against prisoners." *Id.*

<sup>30</sup> See *infra* Part II.D. The inconsistencies are illustrated between the Fifth and Seventh Circuits in *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part & rev'd in part*, 679 F.2d 1115 (5th Cir. 1982), and *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525 (7th Cir. 2000).

<sup>31</sup> See *infra* Parts III.A-B.

<sup>32</sup> See *infra* Parts III.A-B.

<sup>33</sup> See *infra* Parts III.A-B.

<sup>34</sup> See *infra* Part III.A.

their rights to adequate mental health care and suggests a two-fold proposal in order to alleviate such barriers.<sup>35</sup> First, consistent guidelines need to be established among the circuits as to the requirements for adequate medical care.<sup>36</sup> More specifically, these guidelines need to include procedures for evaluating and diagnosing the mentally ill, a mandate for training prison guards in mental illness and suicide risk symptoms, and a requirement for referring inmates to trained mental health professionals if such symptoms present themselves.<sup>37</sup> Mandatory evaluations would bridge the gap between mental health professionals and inmates because access to the mental health staff would not depend on the judgment of a guard.<sup>38</sup> Training guards to recognize “red flags” and requiring referrals to the mental health staff would also bridge the gap because guards oversee the daily activities of inmates, but professionals do not see the “red flags” unless they are alerted by the guards.<sup>39</sup> Thus, conducting regular mental health evaluations of inmates and training guards to recognize symptoms and make referrals would make it easier for a mentally ill inmate to gain access to a professional who can diagnose a serious medical need.

The second part of the proposal is to remove the subjective knowledge standard from § 1983 claims for violations of inmates’ Eighth Amendment rights.<sup>40</sup> That way, prison guards could be held liable for deliberate indifference of an inmate’s serious medical need if they *should* have known of the medical need, rather than avoiding liability by claiming they simply *did* not know.<sup>41</sup> This proposal would provide a safeguard if the guidelines in the first part of the proposal are not followed.<sup>42</sup> For instance, if an inmate exhibits signs that he is suicidal,

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<sup>35</sup> See *infra* Part IV.

<sup>36</sup> See *infra* Part IV.A. For a discussion on the disparity between the circuits on what constitutes adequate mental health care, see *infra* text accompanying notes 172-86.

<sup>37</sup> See *infra* Part IV.A. The training of guards should enable them to recognize symptoms of mental illness and signs of a suicide risk, but need not enable them to be able to treat or diagnose mental illness or recognize when an inmate is “faking.” Proper diagnoses and treatment would be accomplished by requiring mandatory referrals by guards to the mental health staff when such symptoms arise.

<sup>38</sup> See *infra* Part IV.A.

<sup>39</sup> See *infra* Part IV.A.

<sup>40</sup> See *infra* Part IV.B.

<sup>41</sup> See *Farmer v. Brennan*, 511 U.S. 825, 837 (1994); see also *infra* text accompanying note 169.

<sup>42</sup> The first part of the proposal suggests procedures for providing evaluations and diagnoses of the mentally ill, training prison guards in mental illness and suicide risk symptoms, and requiring referrals to trained mental health professionals if such symptoms present themselves. See *infra* Part IV.

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but a guard believes the inmate is faking and thus fails to make a referral to mental health staff, the inmate still has a remedy because the guard *should have known* that a serious medical need potentially exists and should have made a referral to trained mental health staff to make such a determination.<sup>43</sup>

## II. BACKGROUND: THE RIGHT TO ADEQUATE MENTAL HEALTH CARE AND THE REMEDY FOR A VIOLATION OF THIS RIGHT

Mental illness plagues the state correctional systems at a rate of nearly one out of every six inmates, according to the Bureau of Justice Statistics.<sup>44</sup> These inmates have the right to needed mental health care, as provided by the Eighth Amendment.<sup>45</sup> However, when this right is violated, mentally ill inmates face barriers to obtaining a remedy that are more difficult for a mentally ill inmate to overcome than physically ill inmates.<sup>46</sup>

First, Part II.A examines the prevalence of mental illness in correctional facilities and what treatment is provided for those inmates.<sup>47</sup> In addition, this Part addresses particular problems that mentally ill inmates face.<sup>48</sup> Next, Part II.B examines the Eighth Amendment, which gives mentally ill inmates the right to be free from cruel and unusual punishment, and subsequent cases that interpret this Amendment as providing a right to mental health treatment.<sup>49</sup> Then, Part II.C introduces the remedy under § 1983 for an infringement of the right to mental health treatment and the two-part test that must be satisfied to prevail on such a claim.<sup>50</sup> This test, called the *Estelle* Test, requires proof that a serious medical need existed and prison officials were deliberately

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<sup>43</sup> See *infra* Part IV.B.

<sup>44</sup> See Paula M. Ditton, Bureau of Justice Statistics: *Special Report, Mental Health and Treatment of Inmates and Probationers 1* (1999), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf>; see also *infra* Part II.A.

<sup>45</sup> See *infra* Part II.B. The Eighth Amendment prohibits the use of cruel and unusual punishment against confined inmates. U.S. CONST. amend. VIII. The Supreme Court held that this amendment provides the right to medical care because failure to provide adequate care constitutes cruel and unusual punishment. *Estelle v. Gamble*, 429 U.S. 97 (1976). Lower courts later extended this right to mental health care. See *supra* note 24 and accompanying text.

<sup>46</sup> For a discussion of the difficulties that mentally ill inmates face in obtaining a remedy, see *infra* Part III.

<sup>47</sup> See *infra* Part II.A.

<sup>48</sup> See *infra* Part II.A.

<sup>49</sup> See *infra* Part II.B.

<sup>50</sup> See *infra* Part II.C.

indifferent to that need.<sup>51</sup> Accordingly, Parts II.C.1 and II.C.2 then examine the two parts of the *Estelle* Test separately and the particular difficulties that mentally ill inmates face in proving each part.<sup>52</sup> Finally, Part II.D addresses the split among the circuits as to what mental health treatment standards are constitutionally acceptable.<sup>53</sup>

#### A. Mental Illness in Correctional Facilities

Mental illness is highly prevalent among prison inmates.<sup>54</sup> The rate of mental illness among prison inmates is three times higher than the general population.<sup>55</sup> According to the Bureau of Justice Statistics, in 1998, nearly one out of every six inmates in state prison facilities suffered from a mental illness.<sup>56</sup> More specifically, 283,800 people with mental illnesses were incarcerated in the United States: approximately 16% (179,200) of state prison inmates; 7% (7,900) of federal inmates; 16% (96,700) of people in local jails; and 16% (547,800) of probationers.<sup>57</sup>

<sup>51</sup> See *infra* Part II.C. The test is named after the case that established it, *Estelle v. Gamble*, 429 U.S. 97 (1976).

<sup>52</sup> See *infra* Parts II.C.1 and II.C.2 (discussing the serious medical need requirement and the deliberate indifference requirement, respectively).

<sup>53</sup> See *infra* Part II.D.

<sup>54</sup> See Ditton, *supra* note 44, at 1. These findings are based on self-reported data from the 1997 Survey of Inmates in State and Federal Correctional Facilities, the 1996 Survey of Inmates in Local Jails, and the 1995 Survey of Adults on Probation. *Id.* at 2. One factor that may attribute to this high prevalence is that many mentally ill people are improperly incarcerated instead of treated in the community. T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 356 (1997) ("Many of these inmates are inappropriately placed in jails and prisons because there is no alternative placement. Community mental health treatment is currently unavailable or inadequate to meet the needs of persons with mental disorders.").

<sup>55</sup> See NAMI, *supra* note 2.

<sup>56</sup> See Ditton, *supra* note 44, at 3. Some commentators have said the data from the U.S. Department of Justice study underestimated the problem. See Walter L. Gordon, III, *Old Wine In Old Bottles: California Mental Defenses at the Dawn of the 21st Century*, 32 SW. U. L. REV. 75, 77 n.16 (2003).

<sup>57</sup> Ditton, *supra* note 44, at 1. Another study conducted jointly for the National Alliance for the Mentally Ill and the Public Citizen's Health Research Group reported that the rate of serious mental illness varies from state to state. Stone, *supra* note 54, at 287-88 (citing E. FULLER TORREY ET AL., CRIMINALIZING THE SERIOUSLY MENTALLY ILL: THE ABUSE OF JAILS AS MENTAL HOSPITALS 13 (1992)). "[S]tates such as Wyoming, Nevada, Idaho, and South Carolina reporting prevalence rates of less than three percent, and states such as Connecticut, Hawaii, and Colorado reporting prevalence rates of more than ten percent." *Id.* at 287. In addition, the study reported a higher prevalence rate of serious mental illness associated with larger jail size. *Id.* "Jails with an average daily population of over one-thousand inmates reported a prevalence rate of 8.7%, while jails with an average daily population of less than fifty inmates reported a prevalence rate of 3.3%." *Id.* at 287-88.



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Other studies have revealed that “between 6.5% and 10% of inmates suffer from a ‘serious’ mental illness, and another 15% to 40% of inmates suffer from a ‘moderate’ mental illness.”<sup>58</sup> Contributing to the already disproportionate number of mentally ill people in prison, the rate of mentally ill inmates continues to rise.<sup>59</sup>

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<sup>58</sup> James R. P. Ogloff, Ronald Roesch & Stephen D. Hart, *Mental Health Services in Jails and Prisons: Legal, Clinical, and Policy Issues*, 18 LAW & PSYCHOL. REV. 109 (1994). In a study of New York prisons, the researchers reached similar results using slightly different terminology. Stone, *supra* note 54, at 288 (reporting that “five percent of the inmates studied were found to have a ‘severe psychiatric disability’ and that ten percent of prison inmates had a ‘significant psychiatric disability’”) (citing Joel A. Dvoskin & Henry J. Steadman, *Chronically Mentally Ill Inmates: The Wrong Concept for the Right Services*, 12 INT’L J. L. & PSYCHIATRY 203, 207 (1989)). For a discussion of what mental conditions qualify as “serious mental illnesses,” see *infra* text accompanying notes 131-32.

<sup>59</sup> Human Rights Watch, *supra* note 1, at 19. The study reported that “[t]here are no national statistics on the historical rates of mental illness among the prison population.” *Id.* However, the study reported that some states have reported a significant increase in the proportion of prison inmates who are diagnosed with a serious mental illness in recent years. *Id.*

For example, the mental health caseload in New York prisons has increased by 73 percent since 1991, five times the prison population increase. In Colorado, the proportion of prisoners with major mental illness was 10 percent in 1998, five to six times the proportion identified in 1988. Between 1993 and 1998 the population of seriously mentally ill prisoners in Mississippi doubled and in the District of Columbia it rose by 30 percent. In Connecticut, the number of prisoners with serious mental illness increased from 5.2 percent to 12.3 percent of the state’s prison population. Indeed, nineteen of thirty-one states responding to a 1998 survey by the Colorado Department of Corrections reported a disproportionate increase in their seriously mentally ill population during the previous five years.

*Id.* The continued rise in the rate of mentally ill inmates in correctional facilities can be attributed to a number of factors. See Stone, *supra* note 54, at 298. One author suggests, “The lack of prison or jail-based drug treatment service programs may prove catastrophic given the absolute increase in the number of persons incarcerated for drug-related offenses, combined with the high prevalence rate of co-occurring drug dependency/abuse and mental disorders.” *Id.* The author explains that these factors, combined with the continued use of jails and prisons as “mental health ‘treatment’ of a last or only resort for persons with severe mental disorders,” lead to the reasonable assumption that the prevalence rate of inmates with severe mental disorders will continue to rise. *Id.* Another factor that contributes to the disproportionate rate of mental illness in correctional facilities is the fact that people with a mental illness are more likely to be arrested than people without a mental illness for commission of the same offense. Olinda Moyd, *Mental Health And Incarceration: What A Bad Combination*, 7 UDC/DCSL L. REV. 201, 208 (2003) (“[P]ersons with mental illness have a sixty percent greater chance of being arrested than those who are not mentally ill but commit the same offense.”). The author also explains that “the rising cost of managed health care, the population growth of jails and prisons, and the punishment of ‘quality of life’ crimes have contributed to the incarceration of thousands of people with mental illness.” *Id.*

Many of these mentally ill inmates have histories of alcohol and drug abuse, as well as physical and sexual abuse.<sup>60</sup> More specifically, inmates with mental illness are more than twice as likely to have suffered from physical abuse and almost four times as likely to have suffered from sexual abuse.<sup>61</sup> In addition, a higher rate of mentally ill inmates experienced a period of homelessness in the year prior to their incarceration.<sup>62</sup> This disparity is highest in federal prisons, where nearly six times as many mentally ill inmates were homeless at some time during the preceding year than other inmates.<sup>63</sup> This disparity is dramatically higher in the number of federal inmates who were homeless at the time of the arrest, with the rate of homelessness being fifteen times higher for the mentally ill as compared to other federal inmates.<sup>64</sup>

Mentally ill inmates face particular problems during their incarceration that are attributable to their illness, but are not affiliated with the illness itself.<sup>65</sup> For example, a prisoner with a mental illness is

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<sup>60</sup> See Ditton, *supra* note 44, at 7. For example, a study of the Cook County Jail in Chicago revealed that over one-third of the inmates with severe mental disorders had a drug-related disorder. Stone, *supra* note 54, at 297; see also Moyd, *supra* note 59, at 208 (explaining that many inmates enter correctional facilities with mental health-related factors, including histories of physical and mental abuse and extensive drug histories). More specifically, as compared to the general population, where twenty percent of adults with mental illness have a co-occurring problem with substance abuse, almost seventy-five percent of inmates with mental illness have co-occurring problems with drug and alcohol abuse. Karen M. Abram & Linda A. Teplin, *Co-Occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy*, 46 AM. PSYCHOLOGIST 1036, 1039, 1044 (1991).

<sup>61</sup> Ditton, *supra* note 44, at 6. The percentage of mentally ill inmates reporting physical abuse was twenty-seven percent, as compared to eleven percent of other inmates. *Id.* The percentage of mentally ill inmates reporting sexual abuse was fifteen percent, while only four percent of other inmates reported such abuse. *Id.*

<sup>62</sup> See *id.* at 5.

<sup>63</sup> See *id.* In federal prisons, 18.6% of mentally ill inmates reported being homeless in the year preceding their incarceration as compared to 3.2% of other inmates. *Id.* In state prisons, the percentage was 20.1% as compared to 8.8% of other inmates. *Id.* In local jails, the percentage was 30.3% as compared to 17.3% of other inmates. *Id.*

<sup>64</sup> See *id.* In federal prisons, 3.9% of mentally ill inmates reported being homeless at the time of arrest as compared to 0.3% of other inmates. *Id.* In state prisons, the percentage was 3.9% as compared to 1.2% of other inmates. *Id.* In local jails, the percentage was 6.9% as compared to 2.9% of other inmates. *Id.*

<sup>65</sup> See Ogloff, Roesch & Hart, *supra* note 58; see also Human Rights Watch, *supra* note 1, at 56 (explaining how mentally ill prisoners are vulnerable to exploitation and extortion). Other commentators have recognized the problems that mentally ill offenders have throughout the entire judicial process, including during the booking procedure. See Marie L. Leahy, *Booking Procedures for the Mentally Ill or Handicap Suspect: Justice Undone*, 29 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 293, 327 (2003). The author suggests that safeguards must be in place to ensure that suspects with mental illnesses are processed properly

considerably more likely than a non-mentally ill inmate to be a victim of physical or sexual assault while incarcerated.<sup>66</sup> This is largely due to the vulnerability that mentally ill inmates have to pressure and intimidation by prison guards to “snitch” on other inmates and from coercion by other inmates to break prison rules.<sup>67</sup> Also, when mentally ill inmates are faced with violence, anti-psychotic medications make them more vulnerable to attack because their reaction times are slowed and they cannot adequately defend themselves.<sup>68</sup>

In addition to heightened risks associated with confinement, mental illness may also affect an inmate’s length of confinement.<sup>69</sup> The

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because mentally challenged people may not be able to protect themselves and their constitutional rights. *Id.* One safeguard is to call upon a trained psychologist once a person with mental illness or handicap is arrested to assess the person and explain things in a way that the mentally challenged person can more easily understand. *Id.* The author notes that society is already beginning to acknowledge that mentally ill people have special needs, demonstrated by the creation of mental health courts. *Id.* However, changes still need to be made in order to protect mentally challenged people who are still “vulnerable targets in this judicial system.” *Id.*

<sup>66</sup> See Dennis Cooley, *Prison Victimization and the Informal Rules of Social Control*, 4 FORUM ON CORR. RESEARCH 31 (1992); see also Human Rights Watch, *supra* note 1, at 57 (“[M]ale and female mentally disordered prisoners are disproportionately represented among the victims of rape.”). In addition to the dangers that other inmates pose to mentally ill inmates, prison staff also contribute to unbearable conditions and physical dangers. Human Rights Watch, *supra* note 1, § 7. The report described prison conditions in the most extreme cases as “truly horrific.” *Id.* § 2. For example, in some cases mentally ill inmates are “locked in segregation with no treatment at all; confined in filthy and beastly hot cells; left for days covered in feces they have smeared over their bodies; taunted, abused, or ignored by prison staff; given so little water during summer heat waves that they drink from their toilet bowls.” *Id.* Furthermore, “[s]uicidal prisoners are left naked and unattended for days on end in barren, cold observation cells.” *Id.* A prison expert recently described one unit in a prison as “medieval . . . cramped, unventilated, unsanitary . . . it will make some men mad and mad men madder.” *Id.* Such horrific treatment of mentally ill inmates may also lead to death, as the report notes that “[p]oorly trained correctional officers have accidentally asphyxiated mentally ill prisoners whom they were trying to restrain.” *Id.*

<sup>67</sup> Human Rights Watch, *supra* note 1, at 56-57 (“[T]hey are intimidated by staff into snitching or they are manipulated by other prisoners into doing things that get them into deep trouble.”). The report further notes that many inmates with mental illness try to avoid the trouble caused by intimidation and coercion by voluntarily isolating themselves in their cells. *Id.* at 57. However, this cannot always be avoided and clearly psychotic or chronically disturbed inmates “are called ‘dings’ and ‘bugs’ by other prisoners, and victimized.” *Id.*

<sup>68</sup> *Id.* (“[Their] anti-psychotic medications slow their reaction times, which makes them more vulnerable to ‘blind-siding’ an attack from the side or from behind by another prisoner.”).

<sup>69</sup> See Ogloff, Roesch & Hart, *supra* note 58. One factor that attributes to mentally ill inmates’ longer lengths of confinement is that mentally ill inmates are less likely to be placed in prison programs that make early release possible. Stone, *supra* note 54, at 357

probability that a mentally ill inmate may receive early or gradual release from prison is ultimately reduced because the inmate's untreated mental illness causes both individual and institutional problems which, in turn, worsen the inmate's mental health functioning.<sup>70</sup> In fact, mentally ill inmates serve a sentence approximately one full year longer on average than non-mentally ill prisoners.<sup>71</sup> The Fourth Circuit recognized this problem, stating that mental illness, which a facility has refused or failed to treat, forms the basis for denying an inmate's release

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("[C]onditions also prevent inmates with severe mental disorders from obtaining access to prison programs or rehabilitation plans which could facilitate release and improve post-release success."). Another factor is the initial placement of mentally ill offenders in higher security facilities. See Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1192-93 (1997).

In a national survey of all state correctional systems, forty-eight of fifty-one responded that they use psychiatric diagnosis in placement decisions; twenty of fifty-one states use maximum security placements for seriously mentally ill inmates, regardless of their actual behavior. Some states bar seriously mentally ill inmates from many, if not all, minimum security facilities. Twenty-two of the thirty states that have them prohibit inmates with major mental disorders, or those who are taking psychotropic medications, from participating in boot camp programs, perhaps the most significant advantage a corrections system can confer on an inmate. Many of these policies, to be sure, are based on lack of mental health resources to monitor the effects of medication at many facilities. Not discrimination per se, but the effect is the same. At a time when the incidence of mentally disordered inmates is growing rapidly, such discrimination is particularly problematic.

*Id.* (citations omitted).

<sup>70</sup> Ogloff, Roesch & Hart, *supra* note 58, at 118. One study describes the deterioration of mental health functioning, which reduces the chances of early release, as the "cycle of decompensation." Human Rights Watch, *supra* note 1, at 3. The cycle begins when security staff places mentally ill inmates in solitary confinement because the staff views them as difficult or disruptive. *Id.* "The lack of human interaction and the limited mental stimulus of twenty-four-hour-a-day life in small, sometimes windowless segregation cells, coupled with the absence of adequate mental health services, dramatically aggravates the suffering of the mentally ill." *Id.* As a result, some inmates' mental state deteriorates so severely that they are required to be placed in a hospital for "acute psychiatric care." *Id.* However, after they are stabilized, the inmates are returned to the same conditions they faced before, and the cycle of decompensation starts all over again. *Id.* The report concludes that "[t]he penal network is thus not only serving as a warehouse for the mentally ill, but, by relying on extremely restrictive housing for mentally ill prisoners, it is acting as an incubator for worse illness and psychiatric breakdowns." *Id.*

<sup>71</sup> Ditton, *supra* note 44, at 8. Increased infractions of prison rules can contribute to denial of a mentally ill inmate's early release and lead to a longer sentence. See Stone, *supra* note 54, at 301 ("[I]nmates with schizophrenia were more likely than control group inmates to have infractions of any given type; have more infractions overall; have more violent infractions; have more days spent in 'lock-up.'").

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on parole.<sup>72</sup> Thus, given the prevalence of mental illness in correctional facilities, mentally ill inmates face additional dangers and problems during their incarceration.<sup>73</sup>

However, treatment for these mentally ill offenders varies greatly among correctional facilities.<sup>74</sup> A 2000 study by the Bureau of Justice Statistics evidences this variance of treatment for offenders, finding that almost three-quarters of all state prison facilities reported that they screen inmates during the intake process.<sup>75</sup> Approximately the same number of facilities provided counseling or therapy to its inmates by trained mental health professionals, while a slightly higher number of

<sup>72</sup> *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977) (explaining “psychological illness (arguably traced to a failure or refusal to treat) becomes the ground for the denial of release itself (i.e., parole)” (cited by Ogloff, Roesch & Hart, *supra* note 58, at 117-18). The court further noted that “deficiencies in health care and hygiene (including the provision of nominal psychological treatment) foster inmate frustration and resentment. These emotions, in turn, ‘thwart the purported goal of rehabilitation,’ and ‘(jeopardize) the ability of inmates to assimilate into the population at large when ultimately released.’” *Id.*

<sup>73</sup> In one article, the author describes how the problems mentally ill inmates face are attributable to the inmates’ poor adjustment to an incarceration environment, concluding that “[i]ncarceration has significant therapeutic implications for persons with severe mental disorders.” Stone, *supra* note 54, at 299. In every measure of adjustment, mentally ill inmates adapt to their incarceration more poorly than non-mentally ill inmates. *Id.* The gravest manifestation of mentally ill inmates’ poor adjustment to incarceration is suicide. *Id.* “Maladaptation to incarceration by inmates with severe mental disorders also implicates other antitherapeutic outcomes, including the worsening of psychiatric symptoms and frequent, as well as intensive mental health hospitalization or treatment, exclusion from prison curricular programs, and disproportionate terms of incarceration relative to inmates without severe mental disorders.” *Id.* Mental illness also causes problems for prison staff, as well as the inmates, due to the difficulties the inmates have in adapting to incarceration. See Lovell & Rhodes, *supra* note 5, at 40. “These difficulties include disruptiveness, unpredictability, inability to follow orders, and the likelihood of being ostracized or victimized by fellow prisoners.” *Id.* Another commentator explains the reasons for disruptive behavior and problems prison personnel have with discipline. See Danielle Drissel, *Massachusetts Prison Mental Health Services: History, Policy and Recommendations*, 87 MASS. L. REV. 106, 118 (2003). The author explains that mental illness lessens the inmates’ ability to adjust to prison and the highly structured environment that is associated with such incarceration. *Id.* As a result, mentally ill inmates are significantly more likely to break prison rules than other inmates. *Id.* Furthermore, “[b]eyond the period of adjustment, an inmate’s mental health needs may be the cause of acts of violence and other ‘bad behavior.’” *Id.* In addition, “how an inmate responds to disciplinary action” may be influenced by his or her mental illness. *Id.*

<sup>74</sup> See Allen J. Beck, Ph.D. & Laura M. Maruschak, Bureau of Justice Statistics: *Special Report, Mental Health Treatment in State Prisons, 2000*, available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtsp00.pdf> (2001). This report is based on the 2000 Census of State and Federal Adult Correctional Facilities, which included 84 federal facilities, 1,320 state facilities, and 260 private correctional facilities, which were in operation on June 30, 2000. *Id.* at 1.

<sup>75</sup> *Id.*

facilities administered psychotropic medications to mentally ill inmates.<sup>76</sup> However, only sixty-five percent of these facilities conducted psychiatric assessments on the prison inmates, and only sixty-six percent of the facilities assisted the inmates in obtaining mental health treatment upon release into the community.<sup>77</sup> In addition, only slightly more than half of prison facilities provided twenty-four hour mental health care for its inmates.<sup>78</sup> Finally, the study revealed that approximately two-thirds of all inmates who received medication, counseling, or other therapy were in facilities that did not specialize in treating mentally ill inmates.<sup>79</sup>

Taking a closer look at these statistics, while nearly seventy percent of state correctional facilities screen inmates upon intake or provide psychiatric assessments, almost ten percent of all facilities in the year 2000 provided no screening or treatment for mental illness at all.<sup>80</sup> Even though screening and treatment may be available at a correctional facility, the inmate may never receive the benefit of medication or counseling.<sup>81</sup> According to the study by the Bureau of Justice Statistics, since entering prison, four out of ten mentally ill state inmates have reported not receiving any treatment, including counseling or medication.<sup>82</sup> The facilities that do offer some mental health care are

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<sup>76</sup> *Id.* “Antipsychotic drugs are used to reduce psychomotor excitement, hallucinations, and delusions in patients with schizophrenia, acute mania, or organic psychosis.” Stone, *supra* note 54, at 305.

<sup>77</sup> See Beck & Maruschak, *supra* note 74, at 1.

<sup>78</sup> *Id.*

<sup>79</sup> *Id.* The exact statistics reported by the Bureau of Justice Statistics are as follows:

Nearly 70% of facilities housing State prison inmates reported that, as a matter of policy, they screen inmates at intake; 65% conduct psychiatric assessments; 51% provide 24-hour mental health care; 71% provide therapy/counseling by trained mental health professionals; 73% distribute psychotropic medications to their inmates; and 66% help released inmates obtain community mental health services. About two-thirds of all inmates receiving therapy/counseling or medications were in facilities that didn’t specialize in providing mental health services in confinement.

*Id.*

<sup>80</sup> *Id.* Overall, policies for screening and treatment of mental illness were reportedly higher in State confinement facilities at 95%, than by community-based facilities at 82%. *Id.* at 2. Although many facilities do not provide screening for mental illness, screening is essential for detecting mental health issues. See Moyd, *supra* note 59, at 209. “When mental health issues go undetected the results can be deadly. Historically, inmates at the Jail have made suicide attempts by drinking disinfectant, overdosing on medications, hanging with bed clothing and self-inflicting skin lacerations.” *Id.*

<sup>81</sup> See Ditton, *supra* note 44, at 10.

<sup>82</sup> See Beck & Maruschak, *supra* note 74, at 1. Treatment options for mental illness, which many inmates never receive, include: the use of antipsychotic and antidepressant drugs;

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often ill equipped to handle inmates with severe psychiatric conditions.<sup>83</sup> The lack of understanding mental illness in general by prison personnel leads to ill treatment of offenders instead of adequate care of their mental conditions.<sup>84</sup> Such poor treatment includes putting the mentally ill inmate in physical restraints, placing the inmate in solitary confinement, or subjecting the inmate to some other form of punishment.<sup>85</sup> Thus, while mental illness is widespread in correctional facilities and these inmates face significant problems during their incarceration, *if* facilities are performing evaluations and providing treatment for these offenders at all, they are doing so inconsistently.<sup>86</sup>

*B. Eighth Amendment*

Despite the fact that the treatment needs of many mentally ill prisoners remain completely unmet, inmates have a constitutional right to mental, as well as physical, health care.<sup>87</sup> This right originates in the Eighth Amendment, which prohibits the use of cruel and unusual punishment against prisoners during their confinement.<sup>88</sup> The Eighth Amendment provides that “[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted.”<sup>89</sup> The drafters of the Amendment had the principal concern of protecting prisoners from “torture and other barbar[ous] methods of

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psychotherapy; psychosurgery; and electroconvulsive therapy (ECT). Stone, *supra* note 54, at 305.

<sup>83</sup> See LeRoy L. Kondo, *Therapeutic Jurisprudence: Issues, Analysis and Applications: Advocacy of the Establishment of Mental Health Specialty Courts in the Provision of Therapeutic Justice for Mentally Ill Offenders*, 24 SEATTLE U. L. REV. 373, 377 (2000). “NAMI notes that correctional facilities are ill-equipped to provide adequate mental health care to mentally ill inmates with severe psychiatric illnesses. Mentally ill inmates are frequently punished, physically restrained, or secluded in isolation cells because of the correctional staff’s lack of understanding regarding the nature of mental illness.” *Id.*; see also Stone, *supra* note 54, at 299 (“[M]any prisons and jails are inadequately prepared to meet the needs of inmates with severe mental disorders in order to prevent antitherapeutic maladaptation.”).

<sup>84</sup> See Kondo, *supra* note 83, at 377; see also Human Rights Watch, *supra* note 1, § 8.

<sup>85</sup> See Kondo, *supra* note 83, at 377; see also *supra* notes 7-21 and accompanying text for a disturbing example of jail guards’ treatment of a mentally ill inmate, Pamela Young (giving the reported facts of *Young v. City of Augusta*, 59 F.3d 1160 (11th Cir. 1995)).

<sup>86</sup> See Beck & Maruschak, *supra* note 74, at 1. In the 2000 study, 155 state facilities reportedly had expertise in psychiatric confinement, but a majority of treatment for mentally ill offenders occurs in general confinement facilities. *Id.* Of the 155 specialized facilities, only twelve had mental health as their primary function, while 143 included mental health as part of other specialty functions. *Id.*

<sup>87</sup> See F. COHEN, LEGAL ISSUES AND THE MENTALLY DISORDERED PRISONER (Nat’l Inst. of Corrections, 1988); see also *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

<sup>88</sup> U.S. CONST. amend. VIII.

<sup>89</sup> *Id.*

punishment.”<sup>90</sup> However, interpretation of the Amendment’s protections evolved to encompass “standards of decency that mark the progress of a maturing society.”<sup>91</sup> In *Gregg v. Georgia*,<sup>92</sup> the Supreme Court stated that the “dignity of man” is an underlying principle of the Eighth Amendment and “punishment shall not involve the unnecessary and wanton infliction of pain.”<sup>93</sup> As a result, the Court concluded that the Amendment’s protections include more than just inhumane punishment, but also inhumane conditions of confinement in prisons and jails.<sup>94</sup> In order for conditions to be humane, a prisoner’s basic needs, such as food, clothing, and medical care, must be satisfied.<sup>95</sup>

The Supreme Court first acknowledged a prisoner’s right to medical care in *Estelle v. Gamble*.<sup>96</sup> The *Estelle* Court specifically considered the

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<sup>90</sup> Granucci, *Nor Cruel and Unusual Punishment Inflicted: The Original Meaning*, 57 CAL. L. REV. 839, 842 (1969); see also *Gregg v. Georgia*, 428 U.S. 153, 170 (1976) (quotations omitted).

<sup>91</sup> *Gregg*, 428 U.S. at 173. The Court stated that the prohibitions of the Eighth Amendment are not confined “to ‘barbarous’ methods that were generally outlawed in the 18th century.” *Id.* at 171. Instead, the Court explained that interpretation of the Eighth Amendment has been flexible and dynamic. *Id.* The Court explained that it has already been recognized that “a principle to be vital, must be capable of wider application than the mischief which gave it birth” and concluded that “the Clause forbidding ‘cruel and unusual’ punishments ‘is not fastened to the obsolete but may acquire meaning as public opinion becomes enlightened by a humane justice.’” *Id.* (citations omitted).

<sup>92</sup> *Gregg v. Georgia*, 428 U.S. 153 (1976).

<sup>93</sup> *Id.* at 173.

<sup>94</sup> See *Rhodes v. Chapman*, 452 U.S. 337, 349-50 (1981) (holding that inhumane prison conditions are unconstitutional). In this case, inmates of a maximum security prison in Ohio brought a class action in Federal District Court under 42 U.S.C. § 1983 against prison officials, alleging that double celling of inmates (keeping more than one inmate in a cell) was cruel and unusual punishment in violation of the Eighth Amendment. *Id.* at 337. The Court held that “[c]onditions of confinement, as constituting the punishment at issue, must not involve the wanton and unnecessary infliction of pain, nor may they be grossly disproportionate to the severity of the crime warranting imprisonment.” *Id.* However, the Court ultimately held that double celling does not necessarily violate the Eighth Amendment. *Id.*

<sup>95</sup> See *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (stating that prisoners have a right to “adequate food, clothing, shelter, and medical care”).

<sup>96</sup> *Estelle v. Gamble*, 429 U.S. 97 (1976). In that case, Gamble was an inmate who suffered a back injury while unloading cotton from a truck in November 1973. *Id.* at 99. When he sought medical attention, he was given pain medication, a pass to remain in his cell, and an order to sleep on a lower bunk bed. *Id.* The guards refused to comply with the bed order. *Id.* In December, before the pain had subsided, Gamble’s cell pass was revoked and he was certified as able to perform light work. *Id.* at 100. Gamble complained that he was in too much pain to work, and was placed in segregation and subsequently taken before the prison disciplinary committee for his failure to work. *Id.* He was sent to see another doctor, who prescribed another medication. *Id.* However, the prescription was not filled for days because prison personnel lost it. *Id.* Through all of December and January, Gamble was kept in segregation. *Id.* at 100-01. At the end of January, Gamble was placed



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adequacy of health care in prisons and held that failure to provide adequate medical care constitutes cruel and unusual punishment, thereby violating the Eighth Amendment, if it rises to the level of "deliberate indifference to serious medical needs of prisoners."<sup>97</sup> The Court reasoned that the government's obligation to provide medical care arises from the basic principles of preserving human dignity and avoiding unnecessary infliction of pain.<sup>98</sup> Because of incarceration, an inmate cannot care for himself and relies on prison personnel to meet his needs, including medical care.<sup>99</sup> The Court found that failure to meet a

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in solitary confinement as punishment for his refusal to work. *Id.* Shortly thereafter, Gamble was hospitalized briefly for back and chest pains and placed on heart medication. *Id.* When he requested to see another doctor for his pain, the guards refused his request for two days. *Id.* In all, Gamble made seventeen attempts to receive a proper diagnosis and treatment for his back injury. *Id.*

<sup>97</sup> *Estelle*, 429 U.S. at 104. The decision has been criticized by some commentators as failing to recognize the distinction between custodial and punitive functions of prisons that ultimately hurts, rather than helps, prison inmates. See Genty, *supra* note 29, at 379-80. "Despite the noble goals of *Estelle*, however, the decision is fundamentally flawed and has had a detrimental impact upon the very prisoners it was intended to protect." *Id.* at 379. The author traces the problems to "the Court's failure to take sufficient account of the realities of the modern prison." *Id.* The idea of imprisonment encompasses the conditions under which confinement occurs, not just the confinement itself and its duration. *Id.* The author explains that "[p]risons are literally miniature cities in which births, deaths, and even marriages occur. Prisons have their own governing structure, police force, industries, schools, medical facilities, housing complexes, and cemeteries. Not all of these aspects of daily prison life fit comfortably within notions of 'punishment.'" *Id.* at 380.

<sup>98</sup> *Estelle*, 429 U.S. at 102-03.

The Amendment embodies "broad and idealistic concepts of dignity, civilized standards, humanity, and decency . . .," against which we must evaluate penal measures. Thus, we have held repugnant to the Eighth Amendment punishments which are incompatible with "the evolving standards of decency that mark the progress of a maturing society" or which "involve the unnecessary and wanton infliction of pain." These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration.

*Id.* (citations omitted).

<sup>99</sup> *Id.* at 103. This idea of reliance on prison personnel due to captivity is more thoroughly described in an article by Fred Cohen. See Fred Cohen, *Captives Right To Mental Health Care*, 17 LAW & PSYCHOL. REV. 1, 1-3 (1993) [hereinafter Cohen, *Captives*]. The author explains that a government assumes the responsibility "to preserve the health and life of a person when the government deprives that person of liberty," meaning the "loss of freedom to move about at will." *Id.* at 1-2. "A captive, by the very nature of involuntary confinement, and without reference to the rationale or objectives of the confinement, simply has no right of *self-determined* access to medical or mental health care." *Id.* at 2. Unless the government provides access to adequate care for sufficiently serious medical or psychological conditions, "the captive will experience needless suffering, possible deterioration or permanent harm, even death." *Id.* The author explains that official custody creates an "affirmative governmental obligation under the Due Process Clause"

prisoner's medical needs could result in unnecessary pain and suffering, or in some cases, even a torturous death.<sup>100</sup> Thus, such a denial would constitute cruel and unusual punishment, in violation of the Amendment.<sup>101</sup> Therefore, the *Estelle* case created a two-part test to establish a violation of the Eighth Amendment regarding the adequacy of medical care: (1) the medical needs of the inmate must be sufficiently serious, and (2) the treatment or lack of treatment must demonstrate deliberate indifference to the needs of the inmate.<sup>102</sup>

While the Supreme Court has recognized prisoners' rights to medical care, the Court has never specifically addressed the right to mental health treatment.<sup>103</sup> However, lower courts have extended this right to the mentally ill.<sup>104</sup> In *Bowring v. Godwin*,<sup>105</sup> the Fourth Circuit in effect removed the distinction between physical and mental health care for Eighth Amendment purposes.<sup>106</sup> The court reasoned that modern science has evolved to include mental illness among the conditions to be treated by medical means.<sup>107</sup> The court stated, "Modern science has

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and the "rationale for this principle is simple." *Id.* When a state government exercises its affirmative power to restrain a person's liberty, that "renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause." *Id.* at 3.

<sup>100</sup> *Estelle*, 429 U.S. at 103-04. The Court stated that inmates are forced to rely on prison personnel to treat medical needs, and if the prison fails to provide treatment, "those needs will not be met." *Id.* at 103. The Court noted that in the worst cases, failure to treat a medical need may cause "physical 'torture or a lingering death,' the evils of most immediate concern to the drafters of the Amendment." *Id.* (citations omitted). Furthermore, even in less serious cases, such a failure would result in pain and suffering, which would not serve any penological purpose. *Id.* "The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common-law view that '(i)t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself.'" *Id.* at 103-04 (citations omitted).

<sup>101</sup> *Id.* at 104.

<sup>102</sup> *Id.* For a more thorough discussion of both parts of the *Estelle* test, see *infra* Part II.C.1 (explaining the serious medical need requirement) and Part II.C.2 (explaining the deliberate indifference requirement).

<sup>103</sup> See Ogloff, Roesch & Hart, *supra* note 58, at 119 ("Unfortunately, the Court has yet to decide a case that directly addresses the extent to which prison and jail inmates have the right to psychological or psychiatric assessment and treatment."). However, the Supreme Court and other appellate courts have decided other cases that "help elucidate the standard of psychiatric or psychological care required by correctional facilities." *Id.*

<sup>104</sup> See *Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977).

<sup>105</sup> *Id.*

<sup>106</sup> *Id.* at 47 ("[W]e see no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart.").

<sup>107</sup> *Id.*

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rejected the notion that mental or emotional disturbances are the products of afflicted souls, hence beyond the purview of counseling, medication and therapy."<sup>108</sup> As a result, the *Bowring* court set up a test for determining an inmate's constitutional right to mental health treatment.<sup>109</sup> The court held that all prison inmates are entitled to psychiatric or psychological treatment according to the following factors: (1) a doctor or other health care provider, using ordinary skill, determines with reasonable certainty that a serious disease or injury is demonstrated by the inmate's symptoms; (2) the disease is capable of considerable alleviation or can be cured; and (3) denial or delay of care could potentially cause further harm.<sup>110</sup> The court further recognized that a prisoner's right to treatment is limited to treatment that is not unreasonably costly or timely and which is medically necessary and not just desired by the prisoner.<sup>111</sup>

Other courts have also held that no logical distinction exists between physical and mental health in terms of a right to treatment.<sup>112</sup> Moreover, since the decision of *Estelle*, in all cases involving deliberate indifference to a prisoner's need for mental health treatment, courts have held this indifference actionable under the Eighth Amendment.<sup>113</sup> As a result, the

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<sup>108</sup> *Id.*

<sup>109</sup> *Id.* at 47-48.

<sup>110</sup> *Id.*

<sup>111</sup> *Id.* ("The right to treatment is, of course, limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable.").

<sup>112</sup> See, e.g., *Steele v. Shah*, 87 F.3d 1266, 1269 (11th Cir. 1996); *Torraco v. Maloney*, 923 F.2d 231, 235 (1st Cir. 1991); *Seifullah v. Toombs*, 940 F.2d 662, 662 (6th Cir. 1991); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir. 1979); *Bowring v. Godwin*, 551 F.2d 44, 47-48 (4th Cir. 1977); *Balla v. Idaho State Bd. of Corrections*, 595 F. Supp. 1558 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980), *modified*, 688 F.2d 266 (5th Cir. 1983).

<sup>113</sup> *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990). This case involved a prison inmate from Georgia, Charles Greason, who was convicted of aggravated assault for firing a gun at a neighbor's house. *Id.* at 831 n.5. While incarcerated in Georgia, Greason committed suicide. *Id.* at 831. The personal representatives of Charles Greason's estate brought an action under 42 U.S.C. § 1983 (1982) in the United States District Court for the Northern District of Georgia. *Id.* The plaintiffs argued that Greason killed himself because prison officials and those who provided his mental health care were deliberately indifferent to his mental needs. *Id.* The plaintiffs claim that this deliberate indifference violated Greason's rights under the Eighth and Fourteenth amendments. *Id.* The facts surrounding the plaintiff's argument began when Greason was charged with aggravated assault and he pled guilty but mentally ill to the assault charges and received a prison sentence of five years. *Id.* at 831. After sentencing, he was taken to the Georgia Diagnostic and Classification Center ("GDCC") for a mental health evaluation and any treatment that may

application of the deliberate indifference standard to serious mental disorders is now clearly ingrained in the judicial system, and the Constitution is violated when a prison fails or refuses to provide adequate mental health care to inmates.<sup>114</sup>

### C. *The Estelle Test*

When an inmate is denied adequate mental health care, violating the Eighth Amendment, the inmate may bring an action under 42 U.S.C. § 1983.<sup>115</sup> This statute provides a civil cause of action when a person's

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be needed. *Id.* After Greason's arrival, GDCC received reports from professionals who had treated Greason in the past, which stated that he had been diagnosed as schizophrenic with suicidal tendencies and had been placed on anti-depressant medication. *Id.* at 832. These reports were placed in Greason's file. *Id.* Greason stayed at GDCC for two and a half months before being seen by a doctor. *Id.* At that time, a doctor spent just a few minutes with Greason and, without even reviewing Greason's file or assessing his mental health status to determine his current potential for suicide, the doctor concluded that Greason's condition had stabilized and that his medication should be discontinued. *Id.* Soon after, Greason attempted suicide, which was reported to prison officials by Greason's parents and two other inmates. *Id.* at 832 n.8. However, the prison officials did nothing in response to the suicide attempt. *Id.* at 833. Less than a month later, Greason was found dead in his cell; he had hung himself with a sweatshirt. *Id.* In defending against the action, the prison officials argued that prison inmates had no clear established constitutional right to psychiatric care. *Id.* The court dismissed this argument and stated that "every reported decision handed down after *Estelle* . . . recognized that deliberate indifference to an inmate's need for mental health care is actionable on eighth amendment grounds." *Id.* at 834. The court further stated that "any reasonably competent prison counselor or administrator would realize that denying a prisoner needed psychotropic drugs might trigger liability under *Estelle*—just as any physician who declined to treat a gangrenous infection with antibiotics might reasonably expect a constitutional challenge." *Id.* The court further recognized that *Estelle* protects inmates beyond the administration of medication. *Id.* The Greason court went on to quote the district court: "Even if this case involved failure to provide psychotherapy or psychological counselling [sic] alone, the court would still conclude that the psychiatric care was sufficiently similar to medical treatment to bring it within the embrace of *Estelle*." *Id.*

<sup>114</sup> Connie M. Mayer, *Unique Mental Health Needs of HIV-Infected Women Inmates: What Services Are Required Under the Constitution and the Americans with Disabilities Act?*, 6 WM. & MARY J. WOMEN & L. 215, 232 (1999).

<sup>115</sup> See 42 U.S.C. § 1983 (2000). The statute provides, in part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable.

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constitutional rights are deprived.<sup>116</sup> To prevail on a § 1983 claim, two requirements must be satisfied.<sup>117</sup> First, the violation must be “committed by a person acting under color of state law.”<sup>118</sup> Because state prison personnel are state employees, they satisfy the “acting under color of state law” requirement for § 1983 claims.<sup>119</sup> Second, the violation must deprive a person of “rights, privileges, or immunities secured by the Constitution or laws of the United States.”<sup>120</sup> Thus, an inmate must prove that he suffered a constitutional violation.<sup>121</sup> The Supreme Court has held that a violation of an inmate’s Eighth Amendment rights is actionable under § 1983.<sup>122</sup> Therefore, to bring a § 1983 claim under the Eighth Amendment, an inmate must satisfy the two-prong test of *Estelle*, proving both a serious medical need and deliberate indifference on the part of the state actor.<sup>123</sup>

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*Id.*

<sup>116</sup> *Id.*

<sup>117</sup> *Parratt v. Taylor*, 451 U.S. 527, 535 (1981), *overruled on other grounds*. In this case, an inmate of the Nebraska Penal and Correctional Complex, a Nebraska prison, ordered hobby materials through the mail. *Id.* at 529. After being delivered to the prison, the packages containing the hobby materials were lost when prison officials failed to perform the normal procedure for receipt of mail packages. *Id.* at 530. The inmate brought an action in Federal District Court under 42 U.S.C. § 1983 against the prison officials to recover the value of the hobby materials, claiming that the prison officials had negligently lost his hobby materials and thereby deprived him of his property without due process of law in violation of the Fourteenth Amendment. *Id.*; see also *Alford v. Haner*, 333 F.3d 972, 975-76 (9th Cir. 2003).

<sup>118</sup> *Parratt*, 451 U.S. at 530.

<sup>119</sup> *Id.* at 535-36. Municipalities and other forms of local government may also satisfy the color of law requirement of a § 1983 claim. See Christy P. Johnson, *Mental Health Care Policies in Jail Systems: Suicide and the Eighth Amendment*, 35 U.C. DAVIS L. REV. 1227, 1236-37 (2002).

<sup>120</sup> *Parratt*, 451 U.S. at 535.

<sup>121</sup> *Id.*

<sup>122</sup> See *Monell v. Dep't. of Soc. Servs.*, 436 U.S. 658 (1978). In this case, female employees of the Department of Social Services and the Board of Education of the City of New York brought a class action lawsuit under 42 U.S.C. § 1983 against the city and other individuals for compelling pregnant employees to take unpaid leaves of absence before such leaves were required for medical reasons. *Id.*

<sup>123</sup> *Estelle*, 429 U.S. at 104. One author describes a three-step process which enables a jail inmate to sue a municipality or other local government under § 1983 for a violation of the jail inmate’s constitutional rights:

Section 1983 enables individuals to sue state actors, such as municipalities, for constitutional violations. Plaintiffs must satisfy three requirements to bring successful section 1983 actions. The first element of a section 1983 claim requires plaintiffs to sue only “persons” for constitutional deprivations. Municipalities and other local government units are persons within the meaning of section 1983. Therefore, in a section 1983 action, plaintiffs can sue the municipality

# 1. Serious Medical Need

While *Estelle* set forth the test for constitutionally mandated care, the Court failed to define one part of its test—“serious medical need.”<sup>124</sup> However, numerous lower courts have accepted the definition of “serious medical need” set forth by the First Circuit in *Gaudreault v. Municipality of Salem, Massachusetts*.<sup>125</sup> In *Gaudreault*, the First Circuit defined serious medical need as a need that “has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor’s attention . . . . The ‘seriousness’ of an inmate’s needs may also be determined by reference to the effect of the delay of treatment.”<sup>126</sup> In addition to a physician’s diagnosis or obvious need for a doctor’s attention, the treatment must be necessary and not just desirable or helpful.<sup>127</sup> Thus, two ways of establishing whether a serious medical

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responsible for the jail that allegedly violated the inmate’s constitutional rights.

The second element of a section 1983 claim requires plaintiffs to prove that the defendant was acting under the authority of state law when the constitutional violation occurred. Municipalities are responsible for administering state law. Municipalities act under authority of state law when they create or sanction policies for the administration of jails. Therefore, the Supreme Court has held that these municipalities are liable under section 1983 for endorsing a policy that violates an inmate’s constitutional rights.

The third element of a section 1983 claim requires plaintiffs to prove that the inmate suffered a constitutional violation. The Supreme Court recognizes that a violation of an inmate’s Eighth Amendment rights is sufficient to successfully bring a section 1983 claim. The Court has also made clear that inadequate medical care policies for inmates violate their Eighth Amendment rights.

See Johnson, *supra* note 119, at 1236-38 (citations omitted).

<sup>124</sup> Fred Cohen & Joel Dvoskin, *Inmates with Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 339, 341 (1992).

<sup>125</sup> *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990).

<sup>126</sup> *Id.* at 208. *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980), sets forth one of the earlier formulations of the test used by the First Circuit. The definition set forth by the First Circuit in *Gaudreault* has been criticized by commentators. See *infra* Part III; see also Cohen & Dvoskin, *supra* note 124, at 341. The authors criticized the definition used by the First Circuit explaining as follows:

[T]he obvious-to-a-layman factor is oft repeated but little explained. A bone protruding through the skin is one kind of layman’s call, while a mental illness is very different. Behavior that one person views as ‘bad’ another characterizes as ‘mad’ and, without more, who may say who is correct?

*Id.*

<sup>127</sup> See *Bowring v. Godwin*, 551 F.2d 44, 48 (4th Cir. 1977).

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need exists are as follows: (1) evidence of a prior diagnosis and treatment; or (2) the obviousness of the need for treatment.<sup>128</sup>

Using this definition of “serious,” evidence of a prior diagnosis or treatment may establish a serious medical need.<sup>129</sup> However, that diagnosis must be made by a “mental health professional—especially a psychiatrist or clinical psychologist,” and the professional must determine that the illness diagnosed is serious.<sup>130</sup> The courts give great deference to the diagnoses of mental health professionals.<sup>131</sup> In addition, some judicial formulations of “serious medical need” are as follows:

The (diagnostic) test is one of medical or psychiatric necessity. . . . Minor aches, pains, or distress will not establish such necessity. . . . A desire to achieve rehabilitation from alcohol or drug abuse, to lose weight to simply look better or in order to feel better, will not suffice. . . . A diagnosis based on professional judgment and resting on some acceptable diagnostic tool, e.g., D.S.M.-III(R), is presumptively valid.<sup>132</sup>

Following these formulations, courts have held that mere depression, behavioral problems, and emotional problems do not qualify as serious mental illnesses.<sup>133</sup> On the other hand, acute depression, paranoid schizophrenia, and nervous collapse have been identified as

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<sup>128</sup> *Gaudreault*, 923 F.2d at 208.

<sup>129</sup> *Id.* However, even if an inmate receives a diagnosis of a serious mental illness, such a diagnosis does not ensure that a court will determine that a serious medical need existed. *See* Cohen & Dvoskin, *supra* note 124, at 341. Instead, the court may choose to rely on a contradictory opinion by another mental health professional. *See id.* (explaining that “even if one doctor diagnoses something as serious, that does not prevent a second medical opinion to the contrary and one upon which a correctional decisionmaker reasonably might choose to rely”).

<sup>130</sup> Cohen & Dvoskin, *supra* note 124, at 341. The authors further explain the process that medical professionals go through when making such a determination. *Id.* First, the professional refers to professional training and norms. *Id.* At the same time, however, the professional should keep in mind that only serious disorders relate to constitutional requirements for treatment. *Id.* Finally, the professional should realize “that among the critical components of that decision are the amount of pain associated with the disorder and the consequences of a delay in providing appropriate care.” *Id.*

<sup>131</sup> *See id.* The Court accepted the use of such deference to mental health professionals’ judgment in *Youngberg v. Romeo*, 457 U.S. 307 (1982). *See id.* at 341 n.35.

<sup>132</sup> *Id.* at 341. Although judicial formulations exist, “[i]n truth, what is or is not viewed as a disorder, and then as serious, will be the subject of the battle of experts.” *Id.*

<sup>133</sup> *Id.* (citing F. COHEN, LEGAL ISSUES AND THE MENTALLY DISORDERED PRISONER 59-60 (Nat’l. Inst. of Corrections, 1988)).

sufficiently serious disorders.<sup>134</sup> Thus, the terminology used by a mental health professional for a diagnosis can mean the difference between crossing the line from a mere problem to a serious medical need.<sup>135</sup>

In addition to evidence of a prior diagnosis and treatment, a court may determine that a serious medical need exists if it is sufficiently obvious to a reasonable person.<sup>136</sup> A serious medical need may be sufficiently obvious if it results in a physical manifestation that can be seen by a reasonable person.<sup>137</sup> For example, blood seeping from a wound would be a physical manifestation that a reasonable person could perceive as warranting medical attention.<sup>138</sup> Courts permit physical

<sup>134</sup> *Id.* at 341-42 ("In accepting or rejecting such diagnostic categories, courts are strongly influenced by accounts of the inmate's behavior."); *see also* Robert E. v. Lane, 530 F. Supp. 930, 939 (N.D. Ill. 1981).

<sup>135</sup> *See* Cohen, *Captives*, *supra* note 99. The author points out that "it is actually the clinicians' choice of the diagnostic terminology which will move these cases from no care to discretionary care or to mandated care." *Id.* This issue of diagnostic control by doctors was also explained in another article. *See* Cohen & Dvoskin, *supra* note 124, at 341. The authors note that medical professionals serve as the "gatekeeper[s] for entry into the world of disease." *Id.* (citing F. Cohen, *The Right to Treatment*, A PRACTITIONER'S GUIDE TO TREATING THE INCARCERATED MALE SEX OFFENDER 155, 157 (B.K. Schwartz, ed., Nat'l Inst. of Corrections, 1988)). The concept of "'disease' is traditionally associated with pathology of tissue." *Id.* However, within the framework of mental illness or disease, "it more nearly resembles a logical or theoretical construct which is not demonstrably valid or invalid. Thus, the various diagnostic categories of mental disease and disorders, as well as individual diagnosis, are in the hands of doctors and other mental health professionals." *Id.*

<sup>136</sup> *See* Johnson, *supra* note 119, at 1248.

<sup>137</sup> *Id.*; *see also* Cohen & Dvoskin, *supra* note 124, at 341 ("A bone protruding through the skin is one kind of layman's call, while a mental illness is very different.").

<sup>138</sup> *See* Johnson, *supra* note 119, at 1248. Although a reasonable person can detect a physical ailment, courts may still apply the deliberate indifference standard inconsistently. *See* Thirty-Second Annual Review of Criminal Procedure, *Substantive Rights Retained By Prisoners*, 91 GEO. L. R. 887, 907 n.2798 (2003). For example, some courts have found deliberate indifference in cases where inmates have physical ailments. *See, e.g.,* Hughes v. Joliet Corr. Ctr., 931 F.2d 425, 427-28 (7th Cir. 1991) (finding deliberate indifference because inmate alleged that prison officials denied him crutches while recovering from spinal injury, and inmate was later diagnosed as paraplegic by specialist); Evans v. Dugger, 908 F.2d 801, 802-04 (11th Cir. 1990) (*per curiam*) (finding deliberate indifference because prison officials failed to provide reasonable accommodation for partially paraplegic inmate and confiscated braces, crutches, and orthopedic shoes); La Faut v. Smith, 834 F.2d 389, 392-94 (4th Cir. 1987) (finding deliberate indifference because prison officials failed to provide an inmate with adequate treatment for a kidney infection and a broken leg, adequate rehabilitation therapy, and handicap bar in inmate's cell or in carpentry shop where inmate worked). On the other hand, courts have also failed to find that prison officials acted with deliberate indifference when inmates had physical ailments. *See, e.g.,* Dunigan v. Winnebago County, 165 F.3d 587, 592 (7th Cir. 1999) (no deliberate indifference found because prison officials were attentive to plaintiff's medical needs during three month period of fatal illness; focus on lapses in care during final weekend of prisoner's life



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manifestations, in the medical context, to be presumed sufficiently obvious to a reasonable person.<sup>139</sup>

While a mental illness may be more difficult to detect than a physical illness, a mental illness may become sufficiently obvious to a reasonable person if it manifests itself physically in the inmate's behavior.<sup>140</sup> This visible indication may be in the form of bizarre or self-destructive behavior, such as masturbating publicly.<sup>141</sup> Thus, if an inmate exhibits such behavior, it would be obvious to a reasonable person that the inmate requires the attention of a mental health professional.<sup>142</sup> Therefore, for an inmate to prevail on a § 1983 claim, under the First Circuit's definition in *Gaudreault*, first a showing must be made of a serious medical need, either by evidence of a prior diagnosis and treatment or by a showing that the need is obvious to a reasonable person.<sup>143</sup>

On the other hand, the Ninth Circuit set forth a different definition for "serious medical need" in 1992.<sup>144</sup> The court described "serious medical need" as follows:

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distorts significant evidence that prison officials provided adequate medical care); *McCormick v. Stalder*, 105 F.3d 1059, 1061 (5th Cir. 1997) (no deliberate indifference found toward medical needs of prisoner when prison officials required that inmate undergo therapy for tuberculosis without his consent); *Shakka v. Smith*, 71 F.3d 162, 167 (4th Cir. 1995) (no deliberate indifference found when inmate deprived of wheelchair because prison psychologist recommended removal of objects that inmate could use in violent manner, and prison officials had no subjective knowledge of deprivation); *LeMaire v. Maass*, 12 F.3d 1444, 1459 (9th Cir. 1993) (no deliberate indifference found when outer door of quiet cell kept open or intercom system maintained between quiet cell and guard cell to afford inmate access to medical services); *Donald v. Wilson*, 847 F.2d 1191, 1194 (6th Cir. 1988) (no deliberate indifference found when prisoner's prosthesis was temporarily confiscated because prosthesis was not medically necessary, prisoner was given crutches, and prisoner had used prosthesis at another prison to carry contraband and as a weapon).

<sup>139</sup> See *Johnson*, *supra* note 119, at 1248. The author explains how the courts allow such a presumption: "Courts routinely permit such presumptions in the medical context, reasoning that medical illness may manifest itself physically, thereby allowing a reasonable person to perceive the need for treatment. For example, a broken bone protruding from the skin is sufficiently obvious to warrant medical attention." *Id.* at 1249.

<sup>140</sup> *Id.*

<sup>141</sup> *Id.* For a description of the forms that bizarre or self-destructive behavior may take, see *Lovell & Rhodes*, *supra* note 5, at 41.

<sup>142</sup> See *Johnson*, *supra* note 119, at 1250.

<sup>143</sup> *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990).

<sup>144</sup> See *McGuckin v. Smith*, 974 F.2d 1050 (9th Cir. 1992). In this case, an inmate in an Arizona state prison, John McGuckin, brought a pro se § 1983 action against several prison medical personnel at the Arizona Department of Corrections alleging that the defendants were deliberately indifferent to his serious medical needs. *Id.* at 1052. McGuckin had

A “serious” medical need exists if the failure to treat a prisoner’s condition could result in further significant injury or the “unnecessary and wanton infliction of pain”. . . . Either result is not the type of “routine discomfort [that] is ‘part of the penalty that criminal offenders pay for their offenses against society’”. . . . The existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual’s daily activities; or the existence of chronic and substantial pain are examples of indications that a prisoner has a “serious” need for medical treatment.<sup>145</sup>

Using either the definition of the First Circuit in *Gaudreault*, or the definition used by the Ninth Circuit, once a serious medical need has been established, the second prong of *Estelle* must be met—that the personnel of the correctional institution were deliberately indifferent to the inmate’s serious medical need.<sup>146</sup>

## 2. Deliberate Indifference

The state of mind that establishes culpability under *Estelle* is “deliberate indifference” to an inmate’s serious medical need.<sup>147</sup> The

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suffered a back injury that required surgery, but he did not receive the needed surgery until he filed the § 1983 claim, which was over three years after the initial injury. *Id.* at 1061-62.

<sup>145</sup> *Id.* at 1059-60 (citations omitted).

<sup>146</sup> *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

<sup>147</sup> *Id.* One author notes:

One of the most intellectual-appearing discussions of deliberate indifference, which culminates in the most defense-oriented of definitions, is by Judge Richard Posner in *Duckworth v. Franzen*. After marking off negligence, recklessness and deliberateness as the three traditional mental elements to be consulted in order to locate the appropriate space for deliberate indifference, Judge Posner states:

If the word “punishment” in cases of prisoner mistreatment is to retain a link with normal usage, the infliction of suffering on prisoners can be found to violate the Eighth Amendment only if that infliction is either deliberate, or reckless in the criminal law sense. Gross negligence is not enough. Unlike criminal recklessness it does not import danger so great that knowledge of the danger can be inferred; and we remind that the “indifference” to the prisoner’s welfare must be “deliberate” . . . implying such knowledge.

Cohen, *Captives*, *supra* note 99, at 24 (citing *Duckworth v. Franzen*, 780 F.2d 645, 652-53 (7th Cir. 1985)).

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Supreme Court noted that in order for an inmate to bring an actionable claim, the inmate must allege acts or omissions on the part of prison officials that are sufficiently harmful to show deliberate indifference.<sup>148</sup> The Court further stated that only indifference that offends developing decency standards violates the Eighth Amendment.<sup>149</sup> However, the Court failed to clearly define what constitutes deliberate indifference.<sup>150</sup>

The lack of guidance by the *Estelle* Court led to a temporary split among the circuits and an inconsistent application of the deliberate indifference standard.<sup>151</sup> While the lower courts generally claimed to apply a recklessness standard to the deliberate indifference test, the courts split as to whether an objective or subjective recklessness standard should be applied.<sup>152</sup> For example, in *Wilks v. Young*,<sup>153</sup> the Seventh Circuit recognized that deliberate indifference is more than “inattention or inadvertence.”<sup>154</sup> “[A]ctual intent or reckless disregard” is required.<sup>155</sup> The court further defined “reckless” as when a defendant “disregards a substantial risk of danger that either is known to him or *would be apparent to a reasonable person in his position*.”<sup>156</sup> Using this definition, liability can be imposed when the defendant subjectively knew of the risk of harm and in circumstances where the defendant had only objective knowledge

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<sup>148</sup> *Estelle*, 429 U.S. at 106.

<sup>149</sup> *Id.* More specifically, the Court stated that “[i]n order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend ‘evolving standards of decency’ in violation of the Eighth Amendment.” *Id.*

<sup>150</sup> See Cohen, *Captives*, *supra* note 99, at 22. The author notes that while the Court did not define the phrase, the Court did make some effort to describe what “deliberate indifference” is not, including the inadvertent failure to provide adequate care. *Id.* Therefore, “a complaint that a physician has been negligent in diagnosing or treating a medical condition does not state a valid claim of medical mistreatment under the Eighth Amendment. Medical malpractice does not become a constitutional violation merely because the victim is a prisoner.” *Id.* (citing *Estelle*, 429 U.S. at 105-06).

<sup>151</sup> Mayer, *supra* note 114, at 236.

<sup>152</sup> *Id.* The disparity between the circuits regarding the recklessness standard can be seen in the differing decisions of *Wilks v. Young*, 897 F.2d 896, 898 (7th Cir. 1990) and *LaMarca v. Turner*, 995 F.2d 1526 (11th Cir. 1993).

<sup>153</sup> 897 F.2d 896 (7th Cir. 1990).

<sup>154</sup> *Id.* at 898. In this case, James E. Wilks, a former inmate at the Waupun Correctional Institution in Wisconsin, filed a civil action for money damages and injunctive relief under 42 U.S.C. § 1983 in the District Court for the Western District of Wisconsin after suffering three personal assaults by a co-inmate at the facility. *Id.* at 897. Wilks alleged that his Eighth Amendment right to be free from cruel and unusual punishment had been violated by the prison’s failure to implement existing prison policies, which may have served to prevent the assaults. *Id.*

<sup>155</sup> *Id.* at 898 (citing *Benson v. Cady*, 761 F.2d 335, 339 (7th Cir. 1985)).

<sup>156</sup> *Id.* (citing *Benson*, 761 F.2d at 339) (emphasis in original).

of that risk.<sup>157</sup> The court further identified the circumstances in which an objective standard could be applied: when the defendant had an objective risk of harm and that risk was substantial.<sup>158</sup> Thus, the Seventh Circuit applied an objective standard to the culpability requirement when the risk of harm was substantial.<sup>159</sup>

On the other hand, the Eleventh Circuit also applied a recklessness standard to deliberate indifference, but reached the opposite conclusion.<sup>160</sup> In *LaMarka v. Turner*,<sup>161</sup> the court stated that in order to establish deliberate indifference, an inmate “must prove that the official possessed knowledge both of the infirm condition and of the means to cure that condition, ‘so that a conscious, culpable refusal to prevent the harm can be inferred from the defendant’s failure to prevent it.’”<sup>162</sup> Thus, the court concluded that deliberate indifference can be shown only when actual knowledge can be proved.<sup>163</sup> Therefore, the Eleventh Circuit required *subjective* knowledge, similar to the standard used in criminal law, rather than a civil law *objective* standard employed by the Seventh Circuit.<sup>164</sup>

In 1994, the Supreme Court resolved the split among the circuits as to whether a subjective or objective recklessness standard should be applied to the deliberate indifference test with the decision of *Farmer v. Brennan*.<sup>165</sup> In that case, Dee Farmer alleged that federal prison officials

<sup>157</sup> *Id.*

<sup>158</sup> *Id.* at 898 n.3 (“An objective knowledge of a risk of harm by itself, however, is not enough to impose liability under the Eighth Amendment. As an additional requirement, the risk must be substantial.”).

<sup>159</sup> *Id.* at 898.

<sup>160</sup> See *LaMarca v. Turner*, 995 F.2d 1526 (11th Cir. 1993).

<sup>161</sup> *Id.*

<sup>162</sup> *Id.* at 1536 (citations omitted). The court further clarified, “Thus, if an official attempts to remedy a constitutionally deficient prison condition, but fails in that endeavor, he cannot be deliberately indifferent unless he knows of, but disregards, an appropriate and sufficient alternative.” *Id.*

<sup>163</sup> *Id.* Ten inmates of Glades Correctional Institution in Florida brought a § 1983 action against a former superintendent of the institution. *Id.* at 1529. The suit originated in 1982 when Anthony LaMarca, an inmate at the prison, “filed a handwritten *pro se* complaint in the district court stating that he had ‘been countlessly approached, threatened with physical violence and assaulted by other inmates at [GCI] because [he] refused to participate in homosexual activities, or pay [for] protection to be left alone.’” *Id.* at 1530-31. LaMarca alleged that the prison offered “a severe lack of protection” and that “the institution seem[ed] unable or unwilling to handle the situation.” *Id.* at 1531.

<sup>164</sup> *Id.* at 1535-36.

<sup>165</sup> See *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). While the decision of *Farmer* resolved the split among the circuits as to whether a subjective or objective recklessness standard should be applied to the deliberate indifference test, the decision did not resolve the

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violated the Eighth Amendment by their deliberate indifference to his safety.<sup>166</sup> Farmer was diagnosed by medical personnel of the Bureau of Prisons as a transsexual.<sup>167</sup> Farmer, who was biologically male, wore women's clothing, underwent hormonal therapy, received breast implants, and had an unsuccessful testicle-removal surgery.<sup>168</sup> Farmer was placed in a prison's general population.<sup>169</sup> Within two weeks, Farmer was beaten and raped by another inmate.<sup>170</sup> Farmer claimed that by placing him in "general population despite knowledge that the penitentiary had a violent environment and a history of inmate assaults, and despite knowledge that [he], as a transsexual who 'projects feminine characteristics,' would be particularly vulnerable to sexual attack" by inmates, constituted deliberate indifference to Farmer's safety, and thus

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inconsistent application of the test in all mental health cases. See *Thirty-Second Annual Review of Criminal Procedure: Substantive Rights Retained by Prisoners*, 91 GEO. L. R. 887, 908 n.2799 (May 2003). For example, in some cases regarding deliberate indifference to a mental health need, both before and after the *Farmer* decision, courts have found that such grounds are actionable as a violation of an inmate's Eighth Amendment rights. See, e.g., *Greason v. Kemp*, 891 F.2d 829, 834 (11th Cir. 1990) (claim stated for failure to provide psychotropic medication); *Wellman v. Faulkner*, 715 F.2d 269, 272 (7th Cir. 1983) (claim stated for failure to attend to mental health needs); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982) (same); *Ramos v. Lamm*, 639 F.2d 559, 574 (10th Cir. 1980) (same); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754, 763 (3d Cir. 1979) (same); *Bowring v. Godwin*, 551 F.2d 44, 47-48 (4th Cir. 1977) (same); cf. *Young v. City of Augusta*, 59 F.3d 1160, 1171-72 (11th Cir. 1995) (holding that the city's failure to adequately train guards to accommodate mentally ill prisoners represented deliberate indifference to inmate's mental health). On the other hand, some courts have failed to find deliberate indifference to an inmate's mental health needs in certain cases, both before and after the decision of *Farmer*. See, e.g., *Estate of Novack v. County of Wood*, 226 F.3d 525, 530 (7th Cir. 2000) (holding that the deliberate indifference standard was not met when an inmate committed suicide because jail personnel were subjectively unaware that the inmate posed high suicide risk and when there was no pattern of suicides to demonstrate that the county was aware of inadequate mental illness treatment policies); *Gregoire v. Class*, 236 F.3d 413, 419 (8th Cir. 2000) (holding that deliberate indifference was not established when a prison manager did not immediately respond to a prisoner's suicide threat when the manager had no previous reason to believe the prisoner was suicidal); *Sibley v. LeMaire*, 184 F.3d 481, 489 (5th Cir. 1999) (holding that there was no deliberate indifference when officer failed to call a doctor for worsening prisoner's mental health); *Torraco v. Maloney*, 923 F.2d 231, 234 (1st Cir. 1991) (holding that no deliberate indifference was demonstrated in suicide case).

<sup>166</sup> *Farmer*, 511 U.S. at 829.

<sup>167</sup> *Id.* A transsexual is one who has "[a] rare psychiatric disorder in which a person feels persistently uncomfortable about his or her anatomical sex, and who typically seeks medical treatment, including hormonal therapy and surgery, to bring about a permanent sex change." *Id.* (citing AMERICAN MEDICAL ASSOCIATION, *ENCYCLOPEDIA OF MEDICINE* 1006 (1989) and AMERICAN PSYCHIATRIC ASSOCIATION, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* 74-75 (3d rev. ed. 1987)).

<sup>168</sup> *Farmer*, 511 U.S. at 829.

<sup>169</sup> *Id.* at 830.

<sup>170</sup> *Id.*

violated the Eighth Amendment.<sup>171</sup> However, the Court held that the definition of deliberate indifference was more closely aligned with the definition used in criminal law.<sup>172</sup>

The Court held that prison personnel cannot be found liable for violating the Eighth Amendment for subjecting an inmate to inhumane conditions of confinement unless they know of and ignore an excessive risk to the inmate's safety or health.<sup>173</sup> The Court further clarified that the prison official must not only be aware of certain facts from which one could draw the inference that a substantial risk of serious harm existed, but must also draw such an inference.<sup>174</sup> As a result of the *Farmer* decision, in order to establish deliberate indifference, an inmate must prove that prison officials subjectively, or in other words actually, knew of the inmate's serious mental health need and chose to ignore it.<sup>175</sup>

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<sup>171</sup> *Id.* at 831. Mentally ill inmates are particularly vulnerable to physical and sexual attacks by other inmates. See Cooley, *supra* note 4, at 31; see also Human Rights Watch, *supra* note 1, at 57 (noting that "male and female mentally disordered prisoners are disproportionately represented among the victims of rape"). This report further describes how mentally ill inmates are vulnerable to exploitation and extortion. *Id.* at 56.

<sup>172</sup> *Farmer*, 511 U.S. at 837. Some commentators have criticized using the intent-based consideration of criminal law. See Genty, *supra* note 29, at 381. One author explains that focusing on intent is useful in deciding when a custodial duty of care has been breached, "but an intent-based analysis is ill-suited for determining what amounts to cruel and unusual punishment. The result of the attempt to fit all aspects of incarceration into an intent-based framework has been an unwieldy and unworkable set of contextual standards developed by an increasingly fragmented Court." *Id.*

<sup>173</sup> *Farmer*, 511 U.S. at 837.

<sup>174</sup> *Id.* The subjective standard has been criticized by commentators as making claims of psychological deprivation nearly impossible to prove. See Holly Boyer, *Home Sweet Hell: An Analysis of the Eighth Amendment's 'Cruel and Unusual Punishment' Clause as Applied to Supermax Prisons*, 32 SW. U. L. REV. 317, 332-33 (2003) (citing Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 N.Y.U. REV. L. & SOC. CHANGE 477, 542 (1997)). "Because psychological conditions are usually hidden in the minds of the inmates, applying the subjective prong to condition-in-confinement cases would require a prison official to have the requisite training to identify and diagnose psychological conditions." *Id.* at 333. However, prison guards lack psychological expertise, making awareness almost impossible. *Id.* "By virtue of the prison guards' deficiency, courts continually hold guards to a lesser standard in recognizing these conditions. Thus, while psychological deprivations are nonetheless as serious as other, visible or tangible, deprivations, the success of such claims is significantly hindered." *Id.*

<sup>175</sup> See Mayer, *supra* note 114, at 237. "Whether an official has knowledge of a particular need, however, is a question of fact that can be resolved in favor of the inmate if the trier of fact could conclude that the official must have known of the need from the very fact that it was so obvious." *Id.*

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*D. Inconsistent Standards for Constitutionally Acceptable Mental Health Treatment*

While it is established that a mentally ill prisoner may bring an action against a correctional facility for deliberate indifference to a serious mental health need, lower courts have not established consistent legal requirements for adequate mental health care.<sup>176</sup> The extent of the disparity is demonstrated in *Ruiz v. Estelle*<sup>177</sup> and *Estate of Novack ex rel. Turbin v. County of Wood*.<sup>178</sup>

In *Ruiz v. Estelle*, inmates brought a claim against a Texas prison for inadequate mental health care and treatment.<sup>179</sup> The Federal District Court for the Southern District of Texas found that almost all the "treatment" that mentally ill inmates received was the administration of psychotropic medications, used basically to control or subdue the inmates.<sup>180</sup> "Other options, such as counseling, group therapy, individual psychotherapy, or assignment to constructive, therapeutic activities are rarely, if ever, available on the units."<sup>181</sup> As a result, many mentally ill inmates resorted to suicide attempts and self-mutilation as

<sup>176</sup> Johnson, *supra* note 119, at 1236 n.54. Some commentators have argued that, although some courts have provided that inmates have substantive rights to at least minimal care, limitations imposed by the Supreme Court may pose a barrier for challenging inadequate care. Joel A. Dvoskin, et al., *Note: Powell v. Coughlin and the Application of the Professional Judgment Rule to Prison Mental Health*, 19 MENTAL & PHYSICAL DISABILITY L. REP. 108, 110 (1995). "[T]he primary limitation is that the actions of state officials (both clinicians and administrators) shall be presumed valid, and in general the courts should defer to the 'professional judgment' of 'qualified mental health professionals.'" *Id.* Therefore, limitations on challenging minimum health care may contribute to inconsistencies among correctional facilities. *Id.*

<sup>177</sup> *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part & rev'd in part*, 679 F.2d 1115 (5th Cir. 1982).

<sup>178</sup> *Id.*; *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525 (7th Cir. 2000). The *Ruiz* case was initiated in June of 1972, when David Ruiz, an inmate of the Texas Department of Corrections ("TDC"), filed a lawsuit against the Director of TDC, pursuant to 42 U.S.C. § 1983, seeking declaratory and injunctive relief for alleged violations of his constitutional rights. *Ruiz*, 503 F. Supp. at 1275. Later, Ruiz's suit was consolidated with the suits of seven other TDC inmates. *Id.*

<sup>179</sup> *Id.* at 1332.

<sup>180</sup> *Id.* ("Professional treatment personnel are virtually non-existent on the units. 'Treatment' there consists almost exclusively of the administration of medications, usually psychotropic drugs, to establish control over disturbed inmates.").

<sup>181</sup> *Id.* "Essentially, an inmate with a mental disorder is ignored by unit officers until his condition becomes serious. When this occurs, he is medicated excessively." *Id.* The court further explained that when a mental condition became so severe, the inmate was sometimes shipped to a prison treatment center, which resulted in little more than medication. *Id.* The court characterized shipping mentally ill inmates to the treatment center as "warehousing." *Id.*

desperate cries for help.<sup>182</sup> However, prison security staff often viewed these behaviors as attempts to “manipulate the system” and punished the mentally ill inmates, rather than making arrangements for mental health professionals to counsel or supervise them.<sup>183</sup>

The district court specified the following six requirements of a constitutionally acceptable mental health treatment program for prisons: (1) the prison must have a systematic program of screenings and evaluations of prisoners in order to identify those who need mental health treatment; (2) treatment for prisoners must entail more than just segregation and close supervision; (3) the prison must employ enough trained mental health professionals to be able to identify and treat the mentally ill in an individualized manner; (4) the treating professionals must keep accurate, complete, and confidential records of the mental health treatment process; (5) prisoners cannot be treated with prescriptions for behavior-altering medications in dangerous amounts, by dangerous methods, or without acceptable supervision and periodic evaluations; and (6) the prison must have a program for the identification, treatment, and supervision of suicidal prisoners.<sup>184</sup> The court considered judicial precedent in previous prison cases, considered expert testimony, and applied “the basic principles of minimally adequate care to the specific problem of mental health care” in order to ascertain the six requirements for minimally adequate care.<sup>185</sup>

On the other hand, the Seventh Circuit examined the lack of many of these same requirements in *Estate of Novack ex rel. Turbin v. County of Wood* and found a showing of deliberate indifference insufficient.<sup>186</sup> In that case, Shannon Novack, a schizophrenic jail inmate, committed suicide; although another inmate reported that Novack was behaving strangely and was in need of mental health treatment, the guards did nothing to assist Novack.<sup>187</sup> The dissent identified procedures that were

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<sup>182</sup> *Id.*

<sup>183</sup> *Id.*

<sup>184</sup> *Id.* at 1339.

<sup>185</sup> *Id.*

<sup>186</sup> See *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525, 525 (7th Cir. 2001).

<sup>187</sup> *Id.* at 528. “Shannon Novack was diagnosed . . . as a paranoid schizophrenic who tended to be impulsive and who was a possible suicide risk.” *Id.* at 527. Shortly thereafter, he was arrested for outstanding warrants. *Id.* at 528. During Novack’s incarceration, a fellow inmate “heard Novack pounding on the cell walls on a daily basis and periodically giggling uncontrollably.” *Id.* The inmate reported Novack’s behavior to jail officers and stated that Novack might be in need of mental health treatment. *Id.* However, the jail staff did nothing in response. *Id.* Later, Novack hung himself using a bed sheet. *Id.* “Susan



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lacking at the Wisconsin county jail.<sup>188</sup> First, health care professionals did not conduct health evaluations even when warranted by the initial screening.<sup>189</sup> Second, supervisors were not required to consult with health professionals before removing an inmate from suicide watch.<sup>190</sup> Third, once an inmate was placed on suicide watch, no mental health professional examined the inmate.<sup>191</sup> Finally, like health care evaluations, the health care professional did not conduct suicide risk evaluations even when warranted by the initial screening.<sup>192</sup>

Despite the State's failure to institute these procedures, the court did not find that the State violated the inmates' constitutional rights.<sup>193</sup> The majority held that, while these measures are desirable, they are not mandatory to establish constitutionally acceptable mental health care policies.<sup>194</sup> The court stated: "While we agree with the dissent that there are additional policies that could improve [Wood County Jail's] treatment of its mentally ill inmates, the plaintiffs' proffered evidence does not demonstrate that WCJ's existing policies fall below the constitutional standards mandated by the Eighth Amendment."<sup>195</sup>

From these two cases, it can be seen that courts do not agree on even the most basic minimum standards for adequate mental health care, such as evaluations by mental health professionals.<sup>196</sup> As a result, it may be more difficult for mentally ill inmates to prove deliberate indifference on an institutional level, on top of the already existing burden of proving deliberate indifference on an individual level.<sup>197</sup>

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Turbin, Novack's mother, brought suit on behalf of Novack's estate and on her own behalf against Wood County alleging that the County had deprived her son of his Eighth Amendment rights by having inadequate policies and practices for treating mentally ill inmates and by failing to adequately train [jail] personnel to provide necessary mental health care to her son that would have prevented his suicide." *Id.* at 528-29. The district court granted summary judgment in favor of the county, and Novack's mother appealed. *Id.* at 529.

<sup>188</sup> *Id.* at 535.

<sup>189</sup> *Id.*

<sup>190</sup> *Id.* For a complete analysis specifically addressing policies and procedures regarding inmates' suicide risk in jails, see Johnson, *supra* note 119, at 1236-39.

<sup>191</sup> *Novack*, 226 F.3d at 535.

<sup>192</sup> *Id.*

<sup>193</sup> *Id.* at 532 n.3.

<sup>194</sup> *Id.*

<sup>195</sup> *Id.* For a discussion of the importance of consistent guidelines for establishing a constitutionally acceptable mental health treatment program, see *infra* Part III.

<sup>196</sup> See *supra* notes 172-83 and accompanying text.

<sup>197</sup> See *infra* Part III.

### III. ANALYSIS: THE PROBLEMS MENTALLY ILL INMATES FACE IN PROVING SERIOUS MEDICAL NEED AND SUBJECTIVE DELIBERATE INDIFFERENCE

While courts have established that mentally ill inmates have the constitutional right to adequate mental health treatment, these inmates face a tougher burden than their physically ill counterparts in proving that the right to treatment has been violated.<sup>198</sup> In order to successfully bring a § 1983 claim that his right against cruel and unusual punishment has been violated, the mentally ill inmate may face much difficulty in satisfying the two-part test of *Estelle*: that a serious medical need exists and that the prison officials were deliberately indifferent to that need.<sup>199</sup>

#### A. *Problem 1: Proving a Serious Medical Need Exists*

The mentally ill prisoner must first show that a serious medical need exists.<sup>200</sup> This can be shown using either the definition given by the Ninth Circuit or the definition used by the First Circuit.<sup>201</sup> However, problems arise from using either of these definitions, as both are nearly impossible for a mentally ill inmate to prove. Using the Ninth Circuit's definition, the inmate must show that a significant injury or unnecessary pain would result by failing to treat the condition.<sup>202</sup> This definition may be problematic to the mentally ill inmate as compared to a physically ill inmate because the terms "injury" and "pain" are ambiguous when applied to mental states; however, it is apparent what constitutes an injury in the physical sense.<sup>203</sup> For example, a reasonable person would most likely categorize a broken bone or infection as an injury.<sup>204</sup> However, what constitutes an injury in the mental sense is unclear. As a result, a court may conclude that further psychosis, as a result of not treating a psychotic condition, is not an "injury" but only a mental state.

<sup>198</sup> See generally *infra* Parts III.A and III.B.

<sup>199</sup> *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). This case established a two-part test to establish a violation of the Eighth Amendment regarding the adequacy of medical care: (1) the medical needs of the inmate must be sufficiently serious, and (2) the treatment or lack of treatment must demonstrate deliberate indifference to the needs of the inmate. *Id.*; see also *supra* notes 95-101 and accompanying text.

<sup>200</sup> *Estelle*, 429 U.S. at 104.

<sup>201</sup> For a discussion of the different definitions used by the Circuits, see *supra* notes 122-43 and accompanying text.

<sup>202</sup> *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir. 1992) ("A 'serious' medical need exists if the failure to treat a prisoner's condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.'").

<sup>203</sup> See *supra* notes 135-36 and accompanying text.

<sup>204</sup> See *supra* notes 135-36 and accompanying text.

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Similarly, it is just as unclear what constitutes mental pain according to a court. A reasonable person may or may not conclude that a mental condition, such as psychosis, is painful.<sup>205</sup> Thus, using the Ninth Circuit's definition of serious medical need, an inmate with a mental condition may face a tougher burden than an inmate with a physical illness.

While not as ambiguous in its terminology as the Ninth Circuit, the definition used by the First Circuit may prove just as problematic for an inmate who is attempting to prove a "serious medical need." Under the definition applied in *Gaudreault*, a serious medical need may be shown either by evidence of a prior diagnosis and treatment or by showing the need is obvious to a reasonable person.<sup>206</sup> Evidence of a prior diagnosis may be more elusive for the mentally ill inmate than a physically ill inmate for several reasons. First, a mental health professional may be reluctant to diagnose a condition that is considered a serious mental illness due to lack of available resources for treating the inmate.<sup>207</sup> Thus, the actual diagnosis that an inmate receives in a correctional institution may be just as influenced by the availability of resources as it is influenced by what signs and symptoms lead to the supposed objective diagnosis.<sup>208</sup> Even scientific data may be highly influenced by available

<sup>205</sup> See *supra* notes 142-43 and accompanying text. For example, one court held that "psychological pain" that results from the conditions of solitary confinement is not "pain" that constitutes cruel and unusual punishment. *Toussaint v. McCarthy*, 801 F.2d 1080, 1108 (9th Cir. 1986). But see *Ruiz v. Johnson*, 37 F. Supp. 2d 855, 914 (S.D. Tex. 1999) (noting that pain and suffering caused by extreme psychological deprivation can support a claim of cruel and unusual punishment).

<sup>206</sup> *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990). This definition has been criticized by commentators for several reasons. See Cohen & Dvoskin, *supra* note 124, at 341. The first reason the definition is flawed is that "physicians diagnose minor ailments as calling for minimal care, as in headaches and aspirin, all the time. Thus, a medical diagnosis and prescription for care by itself is hardly determinative of seriousness." *Id.* The second reason is that "even if one doctor diagnoses something as serious, that does not prevent a second medical opinion to the contrary and one upon which a correctional decisionmaker reasonably might choose to rely." *Id.* The third reason is that "there is no mention of a key ingredient from *Estelle v. Gamble*, i.e., preventable pain; the greater the pain and the longer it is endured, the more likely is a supportable diagnosis of 'serious.'" *Id.* The final reason the definition is flawed is that "the obvious-to-a-layman factor is oft repeated but little explained. A bone protruding through the skin is one kind of layman's call, while a mental illness is very different. Behavior that one person views as 'bad' another characterizes as 'mad' and, without more, who may say who is correct?" *Id.*

<sup>207</sup> Cohen, *supra* note 99, at 21 ("A diagnosis in a custodial setting is likely to say as much about the availability of resources . . . as about an objective diagnosis based on signs and symptoms.").

<sup>208</sup> *Id.*; see also Human Rights Watch, *supra* note 1, at 106 ("Diagnoses of malingering or manipulation too often reflect issues of available resources.").

resources, because the lack of resources may be reflected in the number of inmates who are identified as being seriously mentally ill, more so than objective clinical assessments.<sup>209</sup>

In addition to the lack of available resources to treat a serious mental illness, a mental health professional may also be reluctant to diagnose a serious mental illness due to a distrust of the inmate's motivations and truthfulness.<sup>210</sup> A diagnosis may provide the possibility of secondary gain for the inmate, thus creating a motivation for fabricating a mental illness.<sup>211</sup> An inmate may seek a diagnosis in order to be hospitalized, wherein the inmate may enjoy more freedom than on a regular cellblock.<sup>212</sup> Similarly, the hospital setting may provide an escape from a threatening situation in the general population.<sup>213</sup> Likewise, an inmate may seek hospitalization in order to avoid a work assignment, or may even receive a higher pay while hospitalized than on the job.<sup>214</sup> In addition, an inmate may seek a serious mental health diagnosis in order to help set the foundation for an insanity defense or incompetency finding.<sup>215</sup> Thus, considering the possible motivations and secondary gains, a mental health professional's perceptions and opinions may be

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<sup>209</sup> Cohen, *supra* note 99, at 21. "Indeed, even the coldness of epidemiological data may be significantly influenced by the availability of solutions. That is, the number of captives identified as seriously mentally ill may well be responsive to the space and personnel available to deal with them, as opposed to clinically sound assessments." *Id.*

<sup>210</sup> See *id.* at 19 ("In arriving at a judgment of 'seriousness' or disease, the possibility of secondary gain in the jail and prison setting appears to color the perceptions and reactions of mental health professionals."). Thus, the facade of an objective clinical judgment in prisons may mask a basic distrust for the inmate. *Id.*

<sup>211</sup> *Id.*; see also Human Rights Watch, *supra* note 1, at 106. The possibility of secondary gain may lead to an inmate's manipulation, but manipulation may also be necessary to get needed care. Cohen, *supra* note 99, at 19. Some correctional staff are quick to assume the inmate is faking and overlook potential mental illness. *Id.* However, behavior such as self-mutilation can be both manipulative and a symptom of a major mental disorder simultaneously. *Id.* In institutions where the staff either lacks the time or motivation to pay attention to inmates, the inmates must resort to manipulation, such as creating a disturbance or exaggerating his situation, in order to get the attention needed. *Id.* "The less attentive or present the staff, on average, the more manipulative prisoners have to be to get attention, and this is as true for prisoners who are suffering from serious medical or psychiatric ailments as it is for those who are not ill but merely want attention." *Id.* As a result, many seriously mentally ill inmates are simultaneously manipulative to get the care they need. *Id.*

<sup>212</sup> See Cohen, *supra* note 99, at 19.

<sup>213</sup> *Id.*; see also Human Rights Watch, *supra* note 1, at 57 (explaining that many mentally ill inmates voluntarily isolate themselves from other inmates in order to avoid trouble or danger).

<sup>214</sup> See Cohen, *supra* note 99, at 19.

<sup>215</sup> *Id.*

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influenced against a diagnosis.<sup>216</sup> For example, a legislative report on California prisons found that doctors at one major prison exhibited hostile attitudes towards prisoners, and complaints were made that doctors did “not adequately diagnose or treat a patient who was a disciplinary problem at the prison.”<sup>217</sup> This reluctance to diagnose a mental illness creates a particularly high hurdle for a mentally ill inmate in proving that a serious medical need exists because “in general the courts should defer to the ‘professional judgment’ of ‘qualified mental health professionals.’”<sup>218</sup>

Evidence of prior treatment may be just as problematic as a diagnosis for showing that a serious medical need exists, as many correctional institutions do not provide treatment for their mentally ill inmates.<sup>219</sup> For example, the Bureau of Justice Statistics reported that four out of ten mentally ill state inmates reported receiving no treatment of any kind since entering prison.<sup>220</sup> Thus, lack of treatment may not be indicative of a lack of an underlying serious medical need.

If an inmate cannot rely on evidence of a prior diagnosis or treatment, the inmate may attempt to show the second part of the Ninth Circuit’s definition of “serious medical need” – that the condition is so obvious, a reasonable person could easily recognize the need for medical attention.<sup>221</sup> For example, a protruding bone from the skin obviously presents a serious medical need, even to a layperson.<sup>222</sup> However, this prong of the definition may be more difficult to prove for the mentally ill offender.<sup>223</sup> If a mental illness does not manifest itself in the form of bizarre behavior, then signs and symptoms of a serious mental illness,

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<sup>216</sup> *Id.*; see also Human Rights Watch, *supra* note 1, at 4. “[T]he judgment of some mental health professionals working in prisons becomes compromised over time. They become quick to find malingering instead of illness; to see mentally ill prisoners as troublemakers instead of persons who may be difficult but are nonetheless deserving of serious medical attention.” Cohen, *supra* note 99, at 19.

<sup>217</sup> *Estelle v. Gamble*, 429 U.S. 97, 111 n.3 (1976) (citing ASSEMBLY SELECT COMMITTEE ON PRISON REFORM AND REHABILITATION, AN EXAMINATION OF CALIFORNIA’S PRISON HOSPITALS 60-61 (1972)).

<sup>218</sup> Joel A. Dvoskin, et al., *supra* note 176, at 110.

<sup>219</sup> See *supra* Part II.A.

<sup>220</sup> See Beck & Maruschak, *supra* note 74.

<sup>221</sup> See *Gaudreault v. Municipality of Salem, Mass.*, 923 F.2d 203, 208 (1st Cir. 1990).

<sup>222</sup> See *supra* notes 134-37 and accompanying text.

<sup>223</sup> See Cohen, *supra* note 99, at 19.

which are obvious to a mental health professional, may not be obvious to a layperson.<sup>224</sup>

This presents a particular problem for the mentally ill inmate in proving that a serious medical need was sufficiently obvious to a prison guard, or layperson.<sup>225</sup> Because of the difficulty for a layperson to detect a mental illness as compared to a physical illness, a number of courts may distinguish the two types of illnesses by reasoning that a condition of the mind is too difficult for a layperson to detect compared to a condition that affects the body.<sup>226</sup> In addition, even professionals who are qualified in the mental health field may disagree on the clinical assessment of a mental illness.<sup>227</sup> As a result, a court may determine that a prison official is not deliberately indifferent to a prisoner's serious mental health need because that need is not satisfactorily obvious to the prison official.<sup>228</sup>

Thus, a prison guard, or layperson, may not be capable of detecting the need for medical attention when a mental condition presents itself.<sup>229</sup> Therefore, the inmate must rely on trained mental health professionals to recognize a serious medical need.<sup>230</sup> This leads to an additional hurdle that a mentally ill inmate must overcome—access to a mental health professional.<sup>231</sup> A study of the Pennsylvania correctional system

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<sup>224</sup> See *id.* Security staff, due to inadequate training, “are frequently unable to differentiate between inmates whose conduct is the result of mental illness and inmates whose conduct is unaffected by disease.” Human Rights Watch, *supra* note 1, at 61 (citing *Coleman v. Wilson*, 912 F. Supp. 1282, 1320 (E.D. Cal. 1995)). As a result, behavior that seems merely disruptive, but does not rise to the level of bizarre, typically is treated with punishment without regard to the cause of the behavior. *Id.* at 2-3.

<sup>225</sup> See Johnson, *supra* note 119, at 1251 (discussing the liability of state jails for deliberate indifference to the serious medical needs of jail inmates).

<sup>226</sup> *Id.* “Courts may reason that, because mental illness affects the mind rather than the body, a layperson may not be able to identify a mental illness.” *Id.* Thus, courts may conclude that a correctional facility is not “deliberately indifferent to an inmate’s serious mental health need because that mental health need is not sufficiently obvious.” *Id.*

<sup>227</sup> *Id.*

<sup>228</sup> *Id.*

<sup>229</sup> See *supra* note 219 and accompanying text.

<sup>230</sup> However, relying on mental health professionals is also problematic because mental health professionals are reluctant to diagnose a serious mental illness due to distrust of an inmate’s sincerity and also lack of available resources. See Cohen, *supra* note 99, at 19, 21; *supra* text accompanying notes 201-15.

<sup>231</sup> See Cohen, *supra* note 99, at 8. The problem of blocked access presents itself in a number of ways, including “needless delay between complaint and response, security personnel actually obstructing available options for access, failure to inform captives of how to obtain aid, and failure to train staff in the recognition and response to symptoms of mental illness.” *Id.*

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illustrates the difficulties that inmates face in obtaining access to professional medical help and adequate diagnosis and treatment.<sup>232</sup> "[T]he prisoner's point of contact with a prison's health care program is the sick-call line. Access may be barred by a guard, who refuses to give the convict a hospital pass out of whimsy or prejudice, or in light of a history of undiagnosed complaints."<sup>233</sup> If the inmate makes it past the first hurdle of getting a hospital pass from a guard, then the inmate "commonly first sees a civilian paraprofessional or a nurse, who may treat the case with a placebo without actual examination, history-taking, or recorded diagnosis. Even seeing the doctor at some prisons produces no more than aspirin for symptoms, such as dizziness and fainting, which have persisted for years."<sup>234</sup>

The problem of access to professional mental health care is attributable to several factors.<sup>235</sup> First, a mental illness and need for medical attention may not be obvious to prison guards, who are the gatekeepers between the inmate and the mental health staff.<sup>236</sup> Thus, the inmate is trapped in a catch-22—the guards do not know a problem exists until a diagnosis is made by a mental health professional, but the inmate cannot get access to a mental health professional until a guard knows there is a problem.<sup>237</sup>

Another factor that contributes to an inmate's access problem is the distrust that prison guards have for inmates.<sup>238</sup> Prison guards, similar to mental health professionals, recognize potential secondary gains which

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<sup>232</sup> *Estelle v. Gamble*, 429 U.S. 97, 111 n.3 (1976) (citing *Health Law Project, Univ. of Pa., Health Care and Conditions in Pennsylvania's State Prisons*, in *Am. Bar Ass'n Comm'n on Corr. Facilities and Serv.*, MEDICAL AND HEALTH CARE IN JAILS, PRISONS, AND OTHER CORRECTIONAL FACILITIES: A COMPILATION OF STANDARDS AND MATERIALS 71, 81-82 (1974)).

<sup>233</sup> *Id.*

<sup>234</sup> *Id.*

<sup>235</sup> See Johnson, *supra* note 119, at 1251; Cohen, *supra* note 99, at 19, 21; Human Rights Watch, *supra* note 1, § 9; Lovell & Rhodes, *supra* note 5, at 41; *infra* text accompanying notes 231-47.

<sup>236</sup> See Johnson, *supra* note 119, at 1251. Guards are not only the gatekeepers to the mental health staff, they are also in the best position to recognize when a mental health need arises. See Human Rights Watch, *supra* note 1, at 75. "Correctional staff experience prisoners at close quarter twenty-four hours a day. They come to know patterns of prisoner behavior and can detect changes in them sometimes better, if not more rapidly, than mental health staff whose interactions with prisoners may be more sporadic." *Id.*

<sup>237</sup> See Johnson, *supra* note 119, at 1251.

<sup>238</sup> See Cohen, *Captives*, *supra* note 99, at 19. The author explained that "the possibility of secondary gain in the jail and prison setting appears to color the perceptions and reactions of . . . security staff." *Id.*

may motivate an inmate to seek a mental illness diagnosis, such as a transfer to a less restrictive hospital setting or avoiding work assignments.<sup>239</sup> Security concerns may also contribute to this general distrust of prison inmates.<sup>240</sup> An inmate who is experiencing a psychotic episode may unknowingly become violent against prison guards or continuously break prison rules simply because he does not comprehend the rules or his actions.<sup>241</sup> Thus, guards may be unwilling to comply with an inmate's request for a mental health evaluation or may be reluctant to believe that the inmate is being truthful about his mental health condition.<sup>242</sup>

The problem of limited or blocked access to mental health professionals may also be attributable to the separation and possible animosity between security and mental health staff.<sup>243</sup> Prison guards are

<sup>239</sup> See *id.*; see also Human Rights Watch, *supra* note 1, at 106 ("Security staff, who lack mental health training, are often quick to assume that prisoners are acting volitionally or manipulatively when they act out.").

<sup>240</sup> See Cohen, *supra* note 99, at 21.

<sup>241</sup> See Human Rights Watch, *supra* note 1, at 31-32. For example, schizophrenia may cause a person to perceive prison as a threatening environment. *Id.* at 31. As a result, the person may act out with violence directed at the prison staff. *Id.* Similarly, bipolar disorder can cause a person to become quickly angered when in a manic phase, resulting in dangerous outbursts. *Id.* at 31-32. Furthermore, severe psychosis, such as schizophrenia, can cause a person to completely misunderstand prison rules. *Id.* at 32. According to Dr. Jeffrey Metzner, a correctional mental health expert and clinical professor of psychiatry at the University of Colorado's Health Sciences Center, "[a] small percentage [of prisoners] don't understand the rules. They're the ones who are psychotic. More common is that prison rules don't mean much to someone hearing voices—that's the least of their problems." *Id.* Dr. Metzner further explains that while a person with paranoid schizophrenia may literally understand a rule, the person may nevertheless perceive a request to abide by that rule as being part of a conspiracy against him. *Id.* "It's less of not understanding and more of acting on distortions." *Id.* A study of inmates in South Carolina revealed that inmates with schizophrenia have higher rates of infractions than non-mentally ill inmates. Stone, *supra* note 54, at 301 ("[I]nmates with schizophrenia were more likely than control group inmates to have infractions of any given type; have more infractions overall; have more violent infractions; have more days spent in 'lock-up.'").

<sup>242</sup> See Cohen, *supra* note 99, at 19, 21.

<sup>243</sup> See Human Rights Watch, *supra* note 1, at 61 ("[T]he question of discipline is at the heart of the inherent tension between the security mission of prisons and mental health considerations."). The authors explain that security staff has a legitimate need to maintain order and they believe security is best accomplished through punishment for rule breaking. *Id.* "Many fear that accommodating mental illness will encourage excuses for misconduct, condone malingering, encourage others to engage in similar misconduct, and promote a general breakdown in order." *Id.* In addition to security staff's animosity towards the mental health staff, the mental health staff also has animosity towards the security staff because they feel subordinate to security staff and are resentful that security decisions take precedent over and undercut their treatment efforts. *Id.* at 109. Furthermore, "[c]orrectional officers often believe mental health professionals coddle their patients, are



reluctant to make special arrangements for an inmate once the mental health staff has determined the inmate is mentally ill because of security concerns.<sup>244</sup> Thus, prison guards may be resentful of the mental health staff for making a diagnosis that causes the guards to make special accommodations.<sup>245</sup> For example, in a 1997 study of the Washington Department of Corrections, the researchers found that “[c]ustodial and mental health professionals were caught in interlocking category traps.”<sup>246</sup> Custodial staff did not feel it was helpful for mental health professionals to explain that some inmates who exhibit bizarre behavior are not mentally ill.<sup>247</sup> “On the other hand, mental health professionals who urged special handling of psychologically fragile inmates—especially when they misbehaved—could be resented or dismissed if front-line staff felt the mental health specialists didn’t properly appreciate the interests of security and the dangers of accommodating manipulative behavior.”<sup>248</sup> The researchers concluded that “[r]igid definitions of the areas of custodial and mental health expertise left workers with scant means of helping each other with problems that crossed the boundaries.”<sup>249</sup> Thus, prison guards may be reluctant to allow an inmate access to mental health professionals because a diagnosis may force the guards to make accommodations that threaten security.<sup>250</sup>

A final factor contributing to an inmate’s deficient access to mental health professionals is the lack of a constitutional standard for minimally

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duped by manipulative prisoners, and don’t sufficiently appreciate security needs. Mental health professionals may view correctional officers as blind to anything but regimentation, control, and punishment.” *Id.* at 76.

<sup>244</sup> *Id.*

<sup>245</sup> Lovell & Rhodes, *supra* note 5, at 40-41.

<sup>246</sup> *Id.*

<sup>247</sup> *Id.* at 40.

<sup>248</sup> *Id.* at 40-41.

<sup>249</sup> *Id.* at 41. Alleviation of the lack of coordination between security and mental health staff may help remedy the problems faced by mentally ill inmates. See Moyd, *supra* note 59, at 212 (“[I]mproved coordination of the existing mental health and corrections staff might be the best remedy to some of the problems described.”).

<sup>250</sup> See Lovell & Rhodes, *supra* note 5, at 41. Training security staff in mental health issues could alleviate the strict separation and animosity between security and mental health staff, ultimately benefiting the mentally ill inmates. See Human Rights Watch, *supra* note 1, at 76. The authors explain that training security staff in mental health issues can help overcome the belief that security and mental health staff “are worlds apart in views, concerns, and methods of handling prisoners.” *Id.* The authors conclude that “[b]etter mental health training for correctional officers and more collaboration between custodial and mental health staff could overcome such stereotypes and redound to the benefit of the mentally ill offenders under the control and supervision of both.” *Id.*

adequate care, including mental health evaluations.<sup>251</sup> As discussed above, the Seventh Circuit determined that while measures such as professional health evaluations or suicide risk evaluations after initial screening are desirable, they are not mandatory to establish constitutionally acceptable mental health care policies.<sup>252</sup> Without these standards in place, including regular evaluations, a mentally ill inmate may never undergo an evaluation or screening by a mental health

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<sup>251</sup> See *supra* Part II.D. Commentators have argued that without consistent policies to ensure access to adequate or appropriate care, the rights set forth in *Estelle* are basically nonexistent:

What, then, are some of the secondary rights attached to this primary right of treatment? Without some anterior duty to diagnose—screen or classify are acceptable near-synonyms—then the right to care is a virtual nullity. Obviously, more captives must be assessed in some fashion than treated, and this, of course, has implications for how some initial treatment decisions are made and then how diagnoses are accomplished when a previously “healthy,” or at least undetected as mentally ill, captive subsequently exhibits signs of serious illness.

The requirement of minimally adequate clinical record—to assure continuity of care, review of the quality and efficacy of care, to aid in future diagnosis, and to respond to legal claims, is yet another secondary right. Implicit in this characterization is that treatment of a mental disorder is not likely to be a one-shot intervention; that treatment will likely be ongoing, although the place, nature, or duration of care will likely vary over time.

Access to minimally adequate care is also an important secondary right. Without ready access to diagnosticians and appropriate mental health professionals as caregivers, the *Estelle*-mandated right to treatment is merely precatory. The issue of ready access presents itself in judicial proceedings in a variety of ways, such as needless delay between complaint and response, security personnel actually obstructing available options for access, failure to inform captives of how to obtain aid, and failure to train staff in the recognition and response to symptoms of mental illness.

Those persons with medical and mental health care responsibilities fall within the province of professionals—persons who by training and experience are qualified to provide diagnosis, treatment, and prognosis. While courts will not likely mandate educational or experience requirements for recruiting security staff, they certainly will insist on appropriate credentials for the surgeon’s knife or the clinician’s pharmacology.

Diagnosis, adequate records, ready access to mandated treatment, and an appropriate level of education or training for caregivers are the crucial secondary rights in this area of law.

Cohen, *supra* note 99, at 8.

<sup>252</sup> See *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525, 532 (7th Cir. 2000).

professional unless security staff deems it necessary.<sup>253</sup> However, prison security personnel do not easily detect mental illness because they are not trained to recognize the symptoms of mental illness.<sup>254</sup> Thus, the need for medical attention may not be obvious to prison guards, who are the gatekeepers to mental health professionals.<sup>255</sup> As a result, access to a trained professional, who may be the only one to find a serious mental health need sufficiently obvious, is blocked because consistent requirements for regular evaluations have not been established. Ultimately, because both the First and Ninth Circuits' definitions are particularly problematic for mentally ill inmates, the inmates face much difficulty in proving the "serious medical need" requirement of the *Estelle* test.

*B. Problem 2: Proving Deliberate Indifference*

If a mentally ill inmate overcomes the obstacle of showing that a serious medical need exists, the next hurdle an inmate faces is proving that prison personnel were deliberately indifferent to that need.<sup>256</sup> The test set forth by the Supreme Court is that a prison official "must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference."<sup>257</sup> Thus, in order to establish deliberate indifference, an

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<sup>253</sup> While such standards that would provide adequate mental health care are currently not in place throughout the judicial system, these standards are generally known to the mental health community. See Human Rights Watch, *supra* note 1, at 4. The known standards include: systematic screening and evaluation for mental illness; procedures to provide inmates with timely access to mental health personnel and services; treatment that includes a range of therapeutic interventions including medication; levels of care including acute and long-term care, inpatient and outpatient care; enough qualified professionals to develop individualized treatment plans and enough personnel to implement such plans; adequate and confidential clinical record keeping; suicide prevention procedures for identifying and treating suicidal prisoners; and discharge planning. *Id.* "Peer review and quality assurance programs help ensure that proper policies on paper are translated into practice inside the prisons." *Id.*

<sup>254</sup> See Human Rights Watch, *supra* note 1, at 76.

<sup>255</sup> See *Estelle v. Gamble*, 429 U.S. 97, 110 n.3 (1976). "When ill, the prisoner's point of contact with a prison's health care program is the sick-call line. Access may be barred by a guard, who refuses to give the convict a hospital pass out . . ." *Id.* (citing *Health Law Project, Univ. of Pa., Health Care and Conditions in Pennsylvania's State Prisons*, in *Am. Bar Ass'n Comm'n on Corr. Facilities and Servs.*, MEDICAL AND HEALTH CARE IN JAILS, PRISONS, AND OTHER CORRECTIONAL FACILITIES: A COMPILATION OF STANDARDS AND MATERIALS 71, 81-82 (1974)).

<sup>256</sup> *Estelle*, 429 U.S. at 105.

<sup>257</sup> *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

inmate must prove that prison officials subjectively knew of the inmate's serious mental health need and chose to ignore it.<sup>258</sup>

Proving subjective knowledge on the part of prison officials may be next to impossible.<sup>259</sup> Unless a mental illness manifests itself in the form of abnormal or bizarre behavior, the serious medical need is concealed in the mind of the mentally ill inmate.<sup>260</sup> Consequently, the need for medical attention may not be obvious to a prison guard who has no professional mental health training.<sup>261</sup> "The lack of psychological expertise among prison guards makes a specific showing of awareness next to impossible. By virtue of the prison guards' deficiency, courts continually hold guards to a lesser standard in recognizing these conditions."<sup>262</sup> Thus, while mentally ill inmates are blocked from mental health professionals by guards acting as gatekeepers, the guards who prevent the inmates from getting professional assistance are shielded from the liability attached to subjective knowledge.<sup>263</sup> Therefore, the mentally ill inmate who is denied access to a mental health professional has no recourse against individual prison security guards, even if the guards should have known of the serious medical need, because the guards can claim they did not have the requisite subjective knowledge of the need.<sup>264</sup>

While the subjective knowledge requirement creates a hurdle in making a claim against prison personnel on an individual level, the requirement also prevents a mentally ill inmate from pursuing a remedy against the correctional facility on an institutional level.<sup>265</sup> One commentator, discussing solitary confinement, describes how a violation of an inmate's rights can occur on an institutional, rather than just on an individual level.<sup>266</sup> "[T]he parties responsible for the severe deprivation are the persons behind the design, construction and implementation . . . . Conditions-in-confinement cases do not involve *one* prison official

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<sup>258</sup> See *id.*

<sup>259</sup> See Boyer, *supra* note 174, at 332-33.

<sup>260</sup> See *id.* For a description of the form that bizarre or self-destructive behavior may take, see Lovell & Rhodes, *supra* note 5, at 41. However, "[p]sychological pain does not always display physical characteristics." Christine M. Rebman, *The Eighth Amendment and Solitary Confinement: The Gap in Protection from Psychological Consequences*, 49 DEPAUL L. REV. 567, 618 (1999).

<sup>261</sup> See Boyer, *supra* note 174, at 333.

<sup>262</sup> *Id.*

<sup>263</sup> See *id.*; see also *supra* note 229.

<sup>264</sup> See Boyer, *supra* note 174, at 332-33.

<sup>265</sup> See *id.* at 332.

<sup>266</sup> See *id.*

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intentionally, knowingly and maliciously harming an inmate. Rather, the evil is rooted in the *design* of complete solitary confinement."<sup>267</sup> However, as previously discussed, lower courts have not established consistent legal requirements for designing an adequate mental health care program.<sup>268</sup> Thus, without requirements for prison mental health treatment policies, proving that prison officials subjectively knew that certain policies or procedures did not meet the needs of mentally ill inmates would be difficult.<sup>269</sup> For example, if an inmate with a severe mental illness is never evaluated by a mental health professional, the facility can avoid liability by claiming that it was unaware that not having a policy for regular screening was inadequate because no consistent guideline for regular screening existed. Another way prison facilities can circumvent deliberate indifference is to claim that inadequate mental health care is due to lack of resources rather than intentional denial of care.<sup>270</sup> As a result, claims against prison facilities could be easily defeated.

Two Supreme Court Justices recognized the problem that the subjective requirement creates.<sup>271</sup> In the dissent of *Estelle*, Justice Stevens argued that the Court attached too much importance to the motivations of prison personnel in determining whether an inmate had suffered cruel and unusual punishment.<sup>272</sup> Justice Stevens argued that the subjective state of mind of prison personnel should not be the focal point, but rather should be the nature of the punishment.<sup>273</sup>

Likewise, Justice White expressed a similar concern in his concurrence in *Wilson*.<sup>274</sup> He noted that inhumane conditions in a prison do not always result from single incidents, but may result from the actions of many prison officials, both inside and outside the prison, over an extensive period of time.<sup>275</sup> Both Justices recognized that the problem with one prison condition, solitary confinement, is traceable to the

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<sup>267</sup> *Id.* (emphasis added).

<sup>268</sup> See Johnson, *supra* note 119, at 1237 n.54; see also, *supra* Part II.D.

<sup>269</sup> See Boyer, *supra* note 174, at 332-33.

<sup>270</sup> Genty, *supra* note 29, at 393 ("[P]rison officials will be able to defeat a § 1983 action challenging inhumane prison conditions simply by showing that the conditions are caused by insufficient funding from the state legislature rather than by any deliberate indifference on the part of the prison officials.") (quoting *Wilson v. Seiter*, 501 U.S. 294, 310-11 (1991)).

<sup>271</sup> See Boyer, *supra* note 174, at 332-33.

<sup>272</sup> *Estelle*, 429 U.S. at 116 (Stevens, J., dissenting); Boyer, *supra* note 174, at 332-33.

<sup>273</sup> *Estelle*, 429 U.S. at 116; Boyer, *supra* note 174, at 332-33.

<sup>274</sup> *Wilson v. Seiter*, 501 U.S. 294, 310 (1991) (White, J., concurring); Boyer, *supra* note 174, at 332-33.

<sup>275</sup> *Wilson*, 501 U.S. at 310; Boyer, *supra* note 174, at 332-33.

design of solitary confinement, not the immediate actions of prison personnel.<sup>276</sup> They noted that applying the subjective prong to cases involving prison conditions, such as solitary confinement, is inherently problematic because the immediate actions are not the source of the problem.<sup>277</sup> Additionally, they noted that requiring subjective intent was both a departure from precedent and impossible to prove on a large number of cases.<sup>278</sup>

Moreover, not only claims of inadequate mental health care, but also almost any claim of cruel and unusual punishment can be circumvented so long as prison officials can show some good faith basis for their actions or omissions.<sup>279</sup> Theoretically, even the use of whips and chains could be justified by claiming that such disciplinary means are necessary to improve security or are needed in facilities that do not have enough resources to employ more guards.<sup>280</sup> Thus, proving subjective knowledge on the part of prison officials, both on an individual level and on an institutional level, may be next to impossible.

Ultimately, proving a “serious medical need” and subjective deliberate indifference poses exceptionally high hurdles for mentally ill inmates to overcome when attempting to obtain a remedy for a violation of their Eighth Amendment right to adequate mental health care. Although these hurdles are significant, establishing consistent guidelines for adequate mental health care and changing the subjective deliberate indifference requirement to an objective standard can lessen these hurdles.

#### IV. PROPOSAL: ESTABLISHING CONSISTENT GUIDELINES FOR ADEQUATE MENTAL HEALTH CARE AND CHANGING THE SUBJECTIVE DELIBERATE INDIFFERENCE REQUIREMENT TO AN OBJECTIVE STANDARD

This Note suggests a two-fold proposal in order to alleviate the particular barriers that mentally ill inmates face when attempting to obtain a remedy for a violation of their right to adequate mental health

<sup>276</sup> *Estelle v. Gamble*, 429 U.S. 97, 116 (1976); *Wilson*, 501 U.S. at 310; Boyer, *supra* note 174, at 332-33.

<sup>277</sup> *Estelle*, 429 U.S. at 116; *Wilson*, 501 U.S. at 310; Boyer, *supra* note 174, at 332-33.

<sup>278</sup> *Estelle*, 429 U.S. at 116; *Wilson*, 501 U.S. at 310; Boyer, *supra* note 174, at 332-33.

<sup>279</sup> *Estelle*, 429 U.S. at 116; *Wilson*, 501 U.S. at 310; Boyer, *supra* note 174, at 332-33.

<sup>280</sup> See Genty, *supra* note 29, at 393. Even the use of dungeons and shackles may satisfy an intent-based test if prisons offer a good-faith justification. *Id.* “A standard focusing primarily on the motivations of the prison administration may, therefore, fail to remedy even those conditions widely viewed as intolerable.” *Id.* (citations omitted).

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care. First, consistent guidelines for adequate mental health care, including systematic screening for mental illness, should be established. Second, the subjective standard should be removed from § 1983 claims for Eighth Amendment violations and an objective standard adopted. Taken together, these changes would reduce the difficulty that mentally ill inmates have in remedying violations of their constitutional rights.

A. *Establishing Consistent Guidelines for Adequate Mental Health Care*

First, consistent guidelines need to be established among the circuits as to the requirements for adequate medical care.<sup>281</sup> More specifically, these guidelines need to include procedures for providing evaluations and diagnoses of the mentally ill, training prison guards in mental illness and suicide risk symptoms, and requiring referrals to trained mental health professionals if such symptoms present themselves.<sup>282</sup> The following guidelines for a constitutionally acceptable mental health treatment program established in *Ruiz v. Estelle* provide a framework for establishing model guidelines for an adequate mental health program:<sup>283</sup>

- (1) The prison must have a systematic program of screenings and evaluations of prisoners in order to identify those who need mental health treatment;
- (2) Treatment for a prisoner must entail more than just segregation and close supervision;
- (3) The prison must employ enough trained mental health professionals to be able to identify and treat the mentally ill in an individualized manner;

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<sup>281</sup> For a discussion on the disparity between the circuits on what constitutes adequate mental health care, see *supra* Part II.D.

<sup>282</sup> Mandatory referrals are essential because guards often see the need for a referral but choose not to make the referral. See Human Rights Watch, *supra* note 1, at 76. Also, training guards when and how to make referrals is important. *Id.* “[A]ll of the correctional officers we interviewed felt that they did not have enough training in recognizing mental illness in inmates and in making decisions about referring inmates for mental health services.” *Id.* (quoting Kenneth Appelbaum, et. al, *Report on the Psychiatric Management of John Salvi in Massachusetts Department of Correction Facilities 1995-1996* 35, 39, submitted to the Massachusetts Department of Correction, January 31, 1997, on file at Human Rights Watch).

<sup>283</sup> 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff’d in part & rev’d in part*, 679 F.2d 1115 (5th Cir. 1982).

(4) The treating professionals must keep accurate, complete, and confidential records of the mental health treatment process;

(5) A prisoner cannot be treated with a prescription for behavior-altering medications in dangerous amounts, by dangerous methods, or without acceptable supervision and periodic evaluations; and

(6) The prison must have a program for the identification, treatment, and supervision of suicidal prisoners.<sup>284</sup>

In addition to the six requirements provided by *Ruiz*, a seventh requirement should be added to complete the model guidelines:

*(7) Security staff must receive adequate training to recognize the basic signs and symptoms of mental illness and the security staff must be required to make referrals to the mental health staff if such signs or symptoms are detected.*<sup>285</sup>

The seventh guideline, requiring adequate training of guards in recognizing the basic signs of mental illness and requiring referrals if such signs are detected, would serve to assist mentally ill inmates in receiving needed treatment if the time between mandatory evaluations is lengthy.<sup>286</sup> Training guards should enable them to recognize symptoms

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<sup>284</sup> *Id.* For a discussion of the inconsistency on constitutionally acceptable mental health treatment standards, see *supra* Part III.D. These requirements are viewed from a judicial perspective, but from a clinical perspective, an adequate mental health care program should include:

- Crisis intervention for short-term treatment, usually in an infirmary for less than ten days;
- Acute care, usually in an inpatient, hospital-type facility;
- Chronic care, including special needs housing for those unable to function in the general population but not needing hospitalization;
- Outpatient services;
- Consultation; and
- Discharge/transfer planning.

Clarence J. Sundram, *Monitoring the Quality and Utilization of Mental Health Services in Correctional Facilities*, 7 D.C. L. REV. 163, 165 (2003) (quoting Jeffrey L. Metzner, *An Introduction to Correctional Psychiatry, Part III*, 26 J. AM. ACAD. PSYCHIATRY & L. 107-15 (1998)).

<sup>285</sup> The italicized language is the contribution of the Author.

<sup>286</sup> See Human Rights Watch, *supra* note 1, at 75. Training guards in mental health issues is especially important. *Id.* Training would not only aid correctional staff to better respond



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of mental illness and signs of a suicide risk, but the training need not enable them to be able to treat or diagnose mental illness or recognize when an inmate is "faking." Proper diagnoses and treatment would be accomplished by the required mandatory referrals by guards to the mental health staff when such symptoms arise. Once these guidelines are adopted, a quality assurance program would ensure that these general guidelines, allowing for individual tailoring by each correctional facility, are effectuated.<sup>287</sup>

These guidelines, providing for systematic screening for mental illness and a program for the identification and supervision of suicidal inmates, would solve the problem of the gap between mental health professionals and inmates and facilitate inmates' timely access to professional and adequate care.<sup>288</sup> Without systematic screenings or

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to problems caused by inmates with mental illness, it would also help them to better assist the mental health staff. *Id.* at 76. Warden Gloria Henry, of California's Valley State Prison for Women, told Human Rights Watch that "[t]hey need more training to give a better idea of how to identify and deal with individuals with mental health issues." *Id.* (quoting Human Rights Watch interview with Gloria Henry, warden, Valley State Prison for Women, California, July 17, 2002). "When you're trained in security, to have people comply with rules and regulations, that's what your expectations are. When you're dealing with people with mental health problems, you need to know how to approach them." *Id.* It has been argued by Professor Hans Toch that the mental health training that guards receive should go beyond "a diluted psychology-101-type lecture format." *Id.* at 78 (quoting Human Rights Watch interview with Hans Toch, February 18, 2003). Instead, he argues that "officers should receive hands-on training that presents officers with real symptoms being experienced by real prisoners in the prisons in which the officers work and that integrates those officers into the mental health teams and case conferences in which prisoners' mental health needs are discussed." *Id.* Currently, mental health training for security staff is lacking in many states, and in 2001, ten states reported not providing any training at all. *Id.* at 76. A 2001 report by the National Institute of Corrections revealed that "[t]en prison systems claimed to include roughly four hours of mental health classes in their basic training package for new correctional officers, thirteen admitted to providing fewer than four hours, and only seven stated that they provided more than four hours of training." *Id.* (citing National Institute of Corrections, *Provision of Mental Health Care in Prisons* 9 (2001)).

<sup>287</sup> Clarence J. Sundram, *Monitoring the Quality and Utilization of Mental Health Services in Correctional Facilities*, 7 D.C. L. REV. 163, 169 (2003). Many standard-setting organizations, such as the American Psychological Association ("APA"), recommend quality assurance programs. *Id.* For example, the APA recommends that each facility should have a quality assurance program that describes the goals of the mental health program, the means to achieve those goals, and the means of evaluating these objectives. *Id.* (citing APA GUIDELINES § B.2.a); see also *Madrid v. Gomez*, 889 F. Supp. 1146, 1209 (N.D. Cal. 1995) (explaining that a quality assurance program "is 'standard practice in virtually every health care facility in the country' and is considered a 'fundamental part' of the provision of health care").

<sup>288</sup> See *supra* Part III.A for a discussion of inmates' problem of access to professional mental health care. "[O]ne of the most frequent complaints voiced by mentally ill prisoners

required referrals, an inmate's contact with a mental health professional depends on the judgment of the guards, who oversee the daily activities of inmates.<sup>289</sup> Mandatory evaluations and screening for mental illness would bridge the gap and alleviate the inmate's catch-22 dilemma, which is created because the guards do not know a problem exists until a diagnosis is made by a mental health professional, but the inmate cannot get access to a mental health professional until a guard knows there is a problem.<sup>290</sup> Thus, with mandatory screening of all inmates for mental illness, access to trained mental health professionals would not depend on the judgment of prison guards who may not recognize a serious medical need.<sup>291</sup> This would also avoid the problem of blocked access to mental health staff due to prison guards' distrust of inmates, security concerns, and animosity between security and mental health staff.<sup>292</sup> As a result, the problem that mentally ill inmates have in proving the "serious medical need" prong would be lessened because they would have easier access to the mental health staff who could provide evidence of a diagnosis or recognize a serious medical need.

In addition to solving the problem, the guidelines would be appropriate to adopt because they are attainable for facilities with limited resources.<sup>293</sup> The general guidelines also allow for discretion by prison officials in creating mental health programs.<sup>294</sup> For example, in an impoverished state, a prison could choose to contract with a local health care facility to provide psychiatric care, instead of employing a full-time psychiatrist and staff, if only part-time services are needed for a small mentally ill population. On the other hand, a facility with more

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is that they have to wait days, weeks, and even months to see mental health staff after they request a meeting . . . ." Human Rights Watch, *supra* note 1, at 103-04. A systematic screening should be done early upon the inmate's entry into the correctional system to ensure that adequate care is received on a timely basis. *See id.* at 101. Thus, effective screening should take place within a reasonable time, such as seven days. *Id.* If the screening reveals that the inmate has been receiving mental illness medication or has previously been hospitalized for a mental condition, the inmate should receive a more comprehensive evaluation. *Id.*

<sup>289</sup> *See supra* Part III.A.

<sup>290</sup> *See supra* Part III.A; *see also* Johnson, *supra* note 119, at 1251.

<sup>291</sup> *See supra* Part III.A.

<sup>292</sup> *See supra* Part III.A.

<sup>293</sup> *See Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part & rev'd in part*, 679 F.2d 1115 (5th Cir. 1982).

<sup>294</sup> Courts defer to the discretion of prison personnel. *See Coleman v. Wilson*, 912 F. Supp. 1282, 1301 (E.D. Cal. 1995). "[I]n cases challenging conditions of prison confinement, courts must strike a careful balance between identification of constitutional deficiencies and deference to the exercise of the wide discretion enjoyed by prison administrators in the discharge of their duties." *Id.*

resources could choose to establish an entire separate facility dedicated to the treatment of its mentally ill population. Thus, each correctional facility could establish an individually tailored program based on the facility's unique inmate population, the inmates' needs, and available resources, so long as the basic guidelines are followed.

*B. Changing the Subjective Deliberate Indifference Standard to an Objective Standard*

The second part of the proposal is to remove the subjective standard from § 1983 claims for violations of the Eighth Amendment and adopt an objective standard. That way, prison guards could be held liable if they *should have known* of the medical need, rather than avoiding liability by claiming they simply did not actually know of the need.<sup>295</sup> As a result, the ultimate determination of whether an inmate has been denied adequate mental health care would depend on the impact of prison conditions on the inmate, including existing mental health care policies, rather than the intent of prison officials.<sup>296</sup> Although an objective standard could potentially hold some prison personnel liable for deprivations of mental health care of which they had no actual knowledge, the standard would remove the liability shield for those who simply fail to attempt to recognize a problem. In addition, although the new standard for prison staff is higher under an objective test, that standard is only one of negligence. It is not unreasonable to hold prison staff liable for negligence when they are responsible for people's lives.

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<sup>295</sup> See *Farmer v. Brennan*, 511 U.S. 825, 837 (1994); see also *supra* note 169 and accompanying text for a discussion of the requirement of proof that an official has knowledge of a particular need.

<sup>296</sup> See generally Genty, *supra* note 29, at 380. The author explains how shifting the focus to an impact-based analysis reduces bias against inmates and makes the decision fairer. *Id.* at 393-94. "Focusing on the impact upon the prisoner of prison conditions and guard conduct forces a judge or juror to attempt to empathize with the prisoner, i.e., to see the prison through the prisoner's eyes." *Id.* at 394-95. With the focus on impact, both judges and jurors would question: "How would it be for *me* to live in conditions like that? Those conditions are appalling." If the judge and juror can feel the prison as lived by the prisoner, there is some chance that intolerable conditions or conduct will be found to be cruel and unusual." *Id.* at 395. On the other hand, focusing on intent "reinforces what both judges and jurors are naturally inclined to do anyway: identify with the prison employees (who are like them) and see the prison through their eyes." *Id.* at 395. "Judge and juror are likely to think: 'That could be me in that job. It's hard, and the administration and guards are doing the best they can.'" *Id.* When a prison is viewed through the eyes of prison employees, "as a scary, chaotic place inhabited by sinister and violent 'others,' underfunded and understaffed-even the worst conditions and conduct are unlikely to be found cruel and unusual." *Id.*

Replacing the subjective standard with an objective standard would provide a safeguard if the procedural guidelines in the first part of the proposal, such as systemic screening and mandatory referrals, are not followed. For example, if a guard should have been aware that an inmate is mentally ill based on training for recognizing symptoms, he should make a referral to the mental health staff. However, if the guard fails to make the referral because he believes the inmate is untruthful, the inmate still has a remedy. The guard would be liable under an objective standard because the guard reasonably should have known that a serious medical need existed based on his past training, or at least should have made a referral to trained staff to make such a determination. More specifically, the guard would not be liable under the objective standard if he could not differentiate between an actual symptom and “faking,” but the guard would be liable for failure to make a mandatory referral.

Finally, removing the subjective requirement would also remove the hurdle that inmates face when trying to obtain a remedy for an institutional, rather than individual, violation.<sup>297</sup> An example of the problem with the subjective requirement follows: *if* a prison fails to employ enough mental health staff to adequately meet the needs of the mentally ill inmates, the inmates may be unable to prove that the prison officials, who decide how many people to employ even though they may never actually be present at the prison, consciously knew that the needs of the inmates were going unmet.<sup>298</sup> However, with an objective requirement, the inmates may be able to prove that prison officials should have known of the serious medical need, had hiring policies been evaluated.

If both parts of this proposal are implemented, a mentally ill inmate like Pamela Young, referred to in the introduction of this Note, would either never have experienced such horrific treatment, or could have proved more easily that prison officials were deliberately indifferent to her serious mental health needs.<sup>299</sup> With the guidelines in place, Pamela would have been screened for mental illness and evaluated by a professional. Her treatment would have included more than just being locked in solitary confinement. If she complained that she heard voices, guards would have been required to make an immediate referral to mental health professionals. In addition, guards would have been

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<sup>297</sup> For a discussion of the problem that inmates face in succeeding on a claim on an institutional level, see *supra* notes 259-64 and accompanying text.

<sup>298</sup> See *supra* notes 259-64 and accompanying text.

<sup>299</sup> See *supra* notes 7-21 and accompanying text.

trained to recognize that her bizarre behavior—attempting to flood her cell with urine and repeatedly banging the door—was potentially a symptom of mental illness, also requiring a referral.

However, if the only treatment Pamela received was solitary confinement and being chained to a bed, she could bring a claim against the prison. First, a court would look at whether the prison instituted a mental health program that followed the seven requirements of the model guidelines.<sup>300</sup> If not, the court would find that the prison was deliberately indifferent to Pamela's mental health needs and hold the prison liable for violating her constitutional rights. If the court found that the prison did have a mental health program that followed the requirements, the court would then use an objective standard to evaluate the actions of the guards.<sup>301</sup> As such, the court would determine whether the guards *should have known* that her bizarre behavior and hearing voices were symptoms of a mental illness that required a mandatory referral to the mental health staff. Therefore, it would not be impossible for Pamela to prove that the prison was deliberately indifferent and violated her constitutional right to adequate mental health care.

#### V. CONCLUSION

Mental illness plagues the correctional system at a rate of nearly one out of every six inmates. These inmates have the right to adequate mental health care, as provided by the Eighth Amendment. However, when this right is violated, mentally ill inmates face the high hurdle of proving subjective deliberate indifference to their serious medical needs in order to obtain a remedy for the constitutional violation. Providing consistent guidelines for adequate mental health care that include mandatory screening and evaluations for mental illness, training prison guards in mental illness and suicide risk symptoms, and requiring referrals to trained mental health professionals if such symptoms present themselves, would bridge the gap between security and mental health staff. Following these procedures would also alleviate the barrier to mental health professionals that is created by guards' ignorance of mental illness symptoms, distrust of inmates, security concerns, and animosity between security and mental health staff.

In addition to creating consistent policies and procedures, removing the subjective knowledge component would make remedying a

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<sup>300</sup> For a discussion of the model guidelines, see *supra* text accompanying notes 275-79.

<sup>301</sup> See *supra* text accompanying note 289.

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constitutional violation easier for a mentally ill inmate. Not only could security staff be held liable for violations where the guards should have known of a serious medical need, but also the correctional facility could be held liable for acts or omissions which result in inhumane conditions over a period of time. Taken together, removing the subjective knowledge component and establishing consistent guidelines for adequate mental health care would lessen the difficulty mentally ill inmates have in remedying violations of their constitutional rights.

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